Supreme Court, U.S.

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No. _____

In the Supreme Court of the United States

W. FOX MCKEITHEN, et al.,
Petitioners,

v.

UNITED STATES FIDELITY & GUARANTY CO., et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The United States Court of Appeals for the Fifth Circuit decided an important federal question in a way that conflicts with the majority of the Court's opinions in Eastern Enterprises v. Apfel, 524 U.S. 498, 118 S.Ct. 2131, 141 L.Ed.2d 451 (1998). Did the United States Court of Appeals for the Fifth Circuit improperly interpret the majority of the Court's opinion in Eastern Enterprises to apply the Takings Clause to invalidate the funding mechanism for a vital Louisiana program even though the statute held unconstitutional does not impact an identifiable property interest or fund?

There is a split in the United States Courts of Appeal as to whether Eastern Enterprises supports invalidating a statute other than the Coal Act. The United States Courts of Appeals for the District of Columbia, Third, and Fourth Circuits have refused to extend the Takings Clause analysis of Eastern Enterprises beyond the Coal Act, and then only to parties in a substantially identical position to Eastern Enterprises with respect to both the plurality and Justice Kennedy's concurrence. Is the Takings Clause analysis of Eastern Enterprises properly applied to a non-Coal Act statute that only imposes a general financial assessment against a company without identifying a particular property interest or fund?

Is it proper for the United States Court of Appeals for the Fifth Circuit to grant summary judgment invalidating the funding mechanism for a vital Louisiana program on the basis that it violates the Takings Clause of the United States Constitution even though the Insurers failed to carry their substantial burden of proof in that they failed to present any evidence to support essential elements of their claim?

PARTIES TO THE PROCEEDING

Petitioners

W. FOX MCKEITHEN, Louisiana Secretary of State; KEN DUNCAN, Louisiana State Treasurer; DAN BOUDREAUX, Director of Workers' Compensation of Louisiana; JAMES H. BROWN, Louisiana Commissioner of Insurance; RENEA AUSTIN-DUFFIN, Secretary of Social Services of Louisiana, in their official capacities as members of the Louisiana Workers Compensation Second Injury Board; and GAREY FORSTER, Secretary, Louisiana Department of Labor. Petitioners have no corporate affiliations.

Respondents

UNITED STATES FIDELITY & GUARANTY CO.; FIDELITY & GUARANTY INSURANCE CO.; FIDELITY & GUARANTY INSURANCE UNDERWRITER, INC.; ARGONAUT INSURANCE COMPANY; ARGONAUT MIDWEST INSURANCE COMPANY; ARGONAUT SOUTHWEST INSURANCE COMPANY; COMMERCIAL UNION INSURANCE COMPANY; AMERICAN CENTRAL INSURANCE COMPANY; AMERICAN EMPLOYERS' INSURANCE COMPANY; EMPLOYERS FIRE INSURANCE COMPANY; THE NORTHERN ASSURANCE COMPANY OF AMERICA; UNITED SATES FIRE INSURANCE COMPANY; NORTH RIVER INSURANCE COMPANY; INSURANCE COMPANY OF NORTH AMERICA; BANKER'S STANDARD INSURANCE COMPANY; CENTURY INDEMNITY CO.; CIGNA FIRE UNDERWRITERS INSURANCE COMPANY; CIGNA INSURANCE CO.; CIGNA PROPERTY & CASUALTY INSURANCE COMPANY; CIGNA SPECIALTY INSURANCE COMPANY; INDEMNITY INSURANCE COMPANY OF NORTH AMERICA; PACIFIC EMPLOYERS INSURANCE COMPANY; HARTFORD ACCIDENT AND CASUALTY COMPANY; HARTFORD CASUALTY INSURANCE COMPANY; HARTFORD FIRE INSURANCE COMPANY;

HARTFORD INSURANCE COMPANY OF THE MIDWEST; HARTFORD INSURANCE COMPANY OF THE SOUTHEAST; HARTFORD UNDERWRITERS INSURANCE COMPANY; TWIN CITY FIRE INSURANCE COMPANY; TRAVELERS INSURANCE COMPANY; TRAVELERS INDEMNITY COMPANY OF AMERICA; THE TRAVELERS INDEMNITY COMPANY; THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT; THE TRAVELERS INDEMNITY COMPANY OF ILLINOIS; CHARTER OAK FIRE INSURANCE COMPANY; PHOENIX INSURANCE COMPANY; AETNA CASUALTY & SURETY COMPANY; CIGNA INDEMNITY INSURANCE COMPANY; LIBERTY MUTUAL INSURANCE COMPANY; LIBERTY MUTUAL FIRE INSURANCE COMPANY; and LIBERTY INSURANCE CORPORATION

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OPINIONS BELOW

The September 15, 2000 opinion of the United States Court of Appeals for the Fifth Circuit that gives rise to this petition can be found at U.S. Fidelity & Guar. Co. v. McKeithen, 226 F.3d 412 (5th Cir. 2000). A copy of the Opinion is included as Appendix A. The Fifth Circuit's opinion reversed the decision of the United States District Court for the Middle District of Louisiana, U.S. Fidelity & Guar. Co. v. McKeithen, 39 F.Supp.2d 747 (M.D. La. 1999), holding in favor of the Petitioners ("State Officials") and dismissing this matter. A copy of the District Court's decision is included as Appendix B. By order filed October 25, 2000, the Fifth Circuit denied the suggestion for rehearing *en banc*. A copy of the Order is included as Appendix D.

JURISDICTION

On March 5, 1999, the United States District Court for the Middle District of Louisiana granted summary judgment rejecting the Respondents' ("Insurers") claims that Act 188 of the 1995 Regular Session of the Louisiana Legislature ("Act 188") violated the Takings Clause, the Contracts Clause, and the Equal Protection Clause of the United States Constitution. U.S. Fidelity & Guar. Co. v. McKeithen, 39 F.Supp.2d 747 (M.D. La. 1999). On April 8, 1999, the Insurers filed a notice of appeal to the United States Court of Appeal for the Fifth Circuit. On September 15, 2000, the Fifth Circuit affirmed the district court's ruling denying the Insurers' Contracts Clause claim but reversed the district court's ruling as to the Takings Clause claim. (The Insurers abandoned their Equal Protection Clause claim.) On October 25, 2000, the Fifth Circuit denied State Officials' suggestion for rehearing *en banc*. Pursuant to Supreme Court Rule 13, this petition has been filed within 90 days of the denial of rehearing.

The jurisdiction of the Court is invoked pursuant to 28 U.S.C 1254(1).

CONSTITUTIONAL PROVISION AND STATUTE INVOLVED IN THE CASE

The Takings Clause of the United States Constitution

[N]or shall private property be taken for public use, without just compensation.

Louisiana Revised Statute § 23:1371

1371. Purpose and construction

A. It is the purpose of this Part to encourage the employment of physically handicapped employees who have a permanent, partial disability by protecting employers, group self-insurance funds, and property and casualty insurers from excess liability for workers' compensation for disability when a subsequent injury to such an employee merges with his preexisting permanent physical disability to cause a greater disability than would have resulted from the subsequent injury alone.

B. This Part shall not be construed to create, provide, diminish, or affect in any way the workers' compensation benefits due to an injured employee. The payment of compensation to an injured employee under this Chapter shall be determined without regard to this Part, and the provisions of this Part shall be considered only in determining whether an employer or his insurer is entitled to reimbursement from the Workers' Compensation Second Injury Fund herein created. However, for an accident occurring on or after October 1, 1995, and approved by the Louisiana Workers' Compensation Second Injury Board, the employer, if self-insured, or the insurer shall obtain prior written approval from the board of any lump sum or compromise settlement of the claim as provided for in Part III of this Chapter, to be entitled to reimbursement.

C. As used in this part, the merger of an injury with a preexisting permanent partial disability is limited to the following:

(1) The subsequent injury would not have occurred but for the preexisting permanent partial disability; or

(2) The disability resulting from the subsequent injury in conjunction with the preexisting permanent partial disability is materially and substantially greater than that which would have resulted had the preexisting permanent partial disability not been present, and the employer has been required to pay and has paid compensation for that greater disability.

Louisiana Revised Statute § 23:1377

1377. Worker's compensation second injury fund

A. There is hereby created and established in the state treasury a special fund which shall be designated as the "Workers' Compensation Second Injury Fund," hereinafter referred to as the "fund". The fund shall be maintained as a separate account in the state treasury for the purposes of funding the administrative expenses of the board and reimbursing compensable claims of property and casualty insurers, self-insured employers, and group self-insurance funds as set forth by R.S. 23:1371 *et seq*. Monies shall be withdrawn therefrom only pursuant to legislative appropriation and shall be subject to budgetary control as provided by law. All remaining and unencumbered balances at the end of any fiscal year shall remain credited to the fund and shall be used solely for the purposes stated in this Section.

B. (1) Every property and casualty insurer, individual self-insurer, and group self-insurance fund that has paid Louisiana workers' compensation benefits under Parts II and III, Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950 shall make an annual payment to the fund. The annual reports required by R.S. 23:1291.1(A) shall be used by the board as the base figure for

computing the assessments and such assessments shall be a percentage of the amount reported in the annual reports. The board shall determine the amount of the assessment. Monies collected by the assessment shall not exceed one hundred twenty-five percent of the disbursements made from the fund in the preceding fiscal year.

(2) These funds shall be made payable to the order of the state treasurer and shall be transmitted to the board, which shall in turn transmit all funds so received to the state treasurer. Upon receipt by the state treasurer, the funds shall be credited to the Workers' Compensation Second Injury Fund.

C. (1) The board shall provide by rules and regulations for the collection of the assessment amount. The board shall determine the date the assessment is due and notify, in writing, all property and casualty insurers, self-insured employers, and group self-insurance funds of the assessment at least thirty days before the due date. If such amounts are not paid by the due date established by the board, there may be assessed, for each thirty days that the amount assessed remains unpaid, a civil penalty equal to twenty percent of the amount assessed that remains unpaid, which shall be due and collected at the same time as the unpaid part of the amount assessed.

(2) Any property and casualty insurer that has discontinued writing workers' compensation insurance in this state or any self-insured employer that ceases to be authorized by R.S. 23:1168 or any group self-insurance fund that has ceased to be authorized as a group self-insurance fund shall continue to be liable for payment of any assessment to the fund on account of any benefits paid by the property and casualty insurer, self-insured employer, or group self-insurance fund under Parts II and III of this Chapter.

(3) Any entity that is required by law to make an annual payment or payments into the fund and has not done so shall not be eligible for reimbursement from the fund. In addition, except as provided in R.S. 23:1378(A)(7), any entity that is not required by

law to make such payments into the fund shall not be eligible for reimbursement from the fund.

D. (1) Upon warrant issued by the board, the treasurer shall make payments to employers or insurers entitled thereto under the provisions of this Part. If the funds in the Workers' Compensation Second Injury Fund are insufficient to pay such warrants, claims shall rank from the date of the accident.

(2) A final decision of the board, as provided in R.S. 23:1378(E), decreeing that an employer or insurer is entitled to an award from the Workers' Compensation Second Injury Fund shall have the same effect as such a warrant.

E. If any property or casualty insurer, self-insured employer, or group self-insurance fund fails to pay the amounts assessed against it under the provisions of this Section within sixty days from the time such notice is served upon it, the commissioner of insurance may suspend or revoke the authorization to transact business as provided by law or the office of workers' compensation may suspend or revoke the authorization to be self-insured.

STATEMENT OF THE CASE

The Louisiana legislature created the Workers' Compensation Second Injury Fund ("Fund") in 1974 to encourage the employment of disabled workers. Prior to the Fund, employers who hired disabled workers faced the prospect of paying higher workers' compensation insurance premiums. If a worker with a pre-existing disability suffers a second work-related illness or injury, the combined effect of the original injury and "second injury" may be far more severe than their simple additive consequence. A classic example is a worker, blind in one eye, who loses the other eye in a work related accident. That worker, now completely blind, is entitled to more workers' compensation benefits than if the same accident happened to an able worker, now blind in only one eye. The insurer who pays those benefits will raise the employer's premiums more than if the worker still had one good eye. Thus, employers had a disincentive to hire disabled workers.

The Fund removes this disincentive by spreading the cost of "second injury" benefits. Insurers and self-insured employers[1] still pay the same workers' compensation benefits. The Fund does not create, provide, diminish, or affect in any way the workers' compensation benefits due to an injured employee, La. Rev. Stat. § 23:1371(B). However, the Fund annually assesses each insurer and self-insured employer in proportion to its workers' compensation activity for the prior year, and the Fund uses the money collected to reimburse each insurer or self-insured employer for "second injury" benefits paid during the year. Thus, the cost of reimbursed "second injury" benefits do not impact hiring decisions for the year and encourages employment of disabled employees.

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[1] Employers obtain workers' compensation coverage by paying a premium to an insurance company, or by paying claims themselves. Employers who choose to pay claims themselves are called self-insured employers.

I. LOUISIANA'S SECOND INJURY FUND PRIOR TO ACT 188.

The primary issue in this case is whether Act 188 violates the Takings Clause of the United States Constitution. In particular, the Fifth Circuit's Opinion strikes down the Fund's switch from a premiums-based assessment (a levy upon the gross premiums an insurer collects or a self-insurer would have paid for workers' compensation in a calendar year) to a benefits-based assessment (a levy upon the workers' compensation benefits an insurer or self-insured employer pays in a calendar year) as it applies to the Insurers' pre-1995 workers' compensation insurance policies.

A. Although Benefits-based Assessments Were Recommended, Louisiana Was Forced to Use a Premiums-based Assessment.

Second injury fund model laws,[2] national commissions,[3] and prior second injury funds[4] recommended that second injury funds be financed through a benefits-based assessment. However, prior to the Fund's creation in 1974, Louisiana was not only

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[2]Both the 1965 and 1974 Council of State Governments' model laws recommended that second injury funds be financed by benefits-based assessments. Workmen's Compensation and Rehabilitation Law § 55(c), at 56 (1965); Workmen's Compensation and Rehabilitation Law § 55(c), at 694 (1974).

[3]The Insurer's expert, Mr. Peter S. Barth, was executive director of The National Commission on State Workmen's Compensation Laws from 1971 to 1972. During his tenure, the Commission recommended that "the second injury fund be financed by charges on all carriers, State funds, and self-insuring employers in proportion to the benefits paid by each...." Report of the National Commission on State Workmen's Compensation Laws (1972) pp 22 and 84.

[4]The first second injury fund, created by New York in 1916, was financed through a benefits-based assessment.

unusual in that it had no second injury fund,[5] Louisiana was unique in that it had no workers' compensation commission or other agency which compiled records on "benefits paid." App. E at 49a-50a. The only records available were the Louisiana Insurance Rating Commission's annual reports of the premiums collected by insurance companies. Id. Thus, the Louisiana legislature was forced to use a premiums-based assessment. Id.

B. The Fund Paid Only the Current Year's Expenses Through an Assessment Based Only on the Preceding Year's Premiums.

The annual assessments financed the anticipated cost for only one year of the Fund's reimbursable claims and costs. App. E at 57a; see also former La. Rev. Stat. § 23:1377(A) (West 1985). Indeed, the total amount of money in the Fund was statutorily precluded from exceeding more than 200% of the prior year's disbursements. See former La. Rev. Stat. § 23:1377(C) (West 1985). Thus, the Fund never had, nor was it designed to have, any "reserve" to be used for future years' costs or claims. The assessments were never intended to pay "second injury" benefits beyond the year of assessment.

C. The Premiums-based Assessment Caused Four Problems.

Between 1974 and 1995, it became apparent that premiums-based assessments suffered from at least four serious problems: (1) they were expensive to calculate for self-insured employers; (2) they were inequitable to self-insured employers; (3) they were expensive to administer; and (4) they became almost impossible to administer after 1992.

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[5]In 1972, the National Commission on State Workmen's Compensation Laws reported that Louisiana was one of only four states that had not created a second injury fund.

1. The premiums-based assessment was expensive to calculate.

The Fund could not directly calculate a premiums-based assessment for self-insured employers because self-insured employers do not pay insurance premiums. Therefore, the Fund required self-insured employers to use "manual rates" to **estimate** what they would have paid in premiums. See former La. Rev. Stat. § 23:1377(B) (West 1985).

The National Council on Compensation Insurance, a wholly owned agent of the insurance companies, compiled and published manual rates for each of several hundred job classifications. App. E at 54a. They were expressed for each job classification as "X" dollars per $100 of payroll. Id. A self-insured employer used the manual rate for each employee to compile the "premium" the self-insured employer would have paid. App. E at 51a. Thus, calculating the assessment was expensive for self-insured employers. App. E at 53a. Many self-insured employers had to hire outside CPA's and accounting firms to prepare their assessments. Id.

2. The premiums-based assessment was inequitable.

Besides being expensive to calculate, the manual rates-based assessment was inequitable. Insurance companies seldom used manual rates in determining a premium for their own insured employers. App. E at 54a-55a. For example, employers could reduce their premiums from the manual rate by accepting large deductibles. Id. Other "modifiers" for safety programs, good loss experience, etc., would be reflected in the premiums paid by an insured employer but were not reflected in the manual rates.

To make matters worse, in 1988, regular manual rates were no longer promulgated. App. E at 51a. The only manual rates promulgated were "Assigned Risk Manual Rates" for the Assigned Risk Pool, a pool of employers who could not obtain workers'

compensation insurance. Obviously, the manual rates for employers who were turned down for insurance were extremely high. Id. Thus, self-insured employers started with a higher manual rates-based "premium" than insured employers, and they had no way to reduce their "premium" by using high deductibles or other modifiers.

3. The premiums-based assessment was expensive to administer.

Manual rates-based assessments were not only expensive for self-insured employers, they also raised the cost of administering the Fund. For example, several state agencies wanted the Fund to perform an audit; however, an audit would have been very expensive because auditors would have been required to travel all over the state and even outside the state to verify the number and classifications of each self-insured employers' employees. App. E at 56a.

4. The premiums-based assessment became almost impossible to administer.

The final straw came in 1992 when the Assigned Risk Pool was abolished. As a result, no manual rates, not even Assigned Risk Manual Rates, were promulgated. App. E at 51a. The Fund limped on until 1995 using the Assigned Risk Manual Rates from 1990. Id. Administration problems were exacerbated by the tremendous growth in the number of self-insured employers. In 1974, there were no licensed self-insured employers. App. E at 49a. By 1995, self-insurance had grown to about 50% of all of the workers' compensation insurance in Louisiana. App. E at 51a.

The Fund needed to change its method of assessment. It was almost impossible to continue with a premiums-based assessment when nearly half of the market either could not, or at best would have a most difficult time attempting to, compute premiums without a reliable, creditable, and up-to-date standard. App. E at 52a.

D. The Louisiana Office of Workers' Compensation Administration Has Funded Itself Through a Benefits-based Assessment since 1983.

Since 1983, the Louisiana Office of Workers' Compensation Administration ("OWCA") has compiled an annual report on benefits paid by insurers and self-insured employers. App. E at 50a; see also La. Rev. Stat. § 23:1291. The OWCA has used the annual report to fund itself through an annual benefits-based assessment on insurers and self-insured employers since 1983 without any known objection from the insurance industry. App. E at 53a.

The OWCA annual reports on benefits paid provided the Fund with a simple and inexpensive solution to the premiums-based assessment problems. The annual amount of benefits paid could be more easily calculated and compiled both by self-insured employers and the Fund. Administrative costs would be, consequently, reduced. Id. In addition, the OWCA was already auditing benefits-based assessments; thus, the Fund obtained the benefits of the OWCA's audits at no cost, thereby realizing a huge savings. App. E at 56a.

II. LOUISIANA'S SECOND INJURY FUND AFTER ACT 188.

Act 188 changed the Fund in only one respect. Act 188 changed how the Fund measures workers' compensation activity – the Fund changed from a premiums-based assessment to a benefits-based assessment. The Insurers and self-employers still pay a single annual assessment to the Fund. The assessment is still based solely on their preceding year's activity. The assessment still finances only the Fund's current year's costs and claims, and the Fund still carries no reserve for future years' expenses. The Fund is now statutorily precluded from collecting more than 125% of the prior year's disbursements. La. Rev. Stat. § 23:1377(B).

A. Act 188 Is Not a Penalty Directed at Insurers Who Have Withdrawn From The Louisiana Market For Workers' Compensation Insurance.

Throughout the course of this litigation, the Insurers have argued that Act 188 singles them out for unfair treatment. The Insurers even made an Equal Protection Clause claim. **However, as Magistrate Judge Riedlinger noted, the Insurers' real complaint is that Act 188 does not treat them differently.**[6]

The paragraph of Act 188 about which the Insurers complain merely confirms that Act 188 applies to **all** insurers and self-insured employers who are paying workers' compensation benefits. See La. Rev. Stat. § 23:1377C(2). The paragraph is remarkably similar to language used in both the 1965 and 1974 model laws, Workmen's Compensation and Rehabilitation Law § 55(c), at 56 (1965); Workmen's Compensation and Rehabilitation Law § 55(c), at 694 (1974); and the paragraph is nearly identical to its Michigan counterpart. Mich. Comp. Laws § 418.551(6). These similarities demonstrate that the Louisiana legislature did not single out the Insurers for unequal or unfair treatment. Rather, when the legislature changed the Fund from premiums-based to benefits-based, it adopted the recommendations of the model laws, including those portions recommending that it be made applicable to parties who change their status.

B. Act 188's Benefits-based Assessment Is No Different than Other States' Benefits-based Assessment.

The Insurers have argued that Act 188 is unique because Louisiana is the only state that applies the benefits-based assessment to workers' compensation insurance policies written prior to the

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[6]After Magistrate Judge Riedlinger ruled against and Judge Parker dismissed the Insurers' Equal Protection Clause claim, the Insurers abandoned that claim.

effective date of Act 188. However, every state which uses a benefits-based assessment enacted it and applies it in exactly the same manner as Louisiana. **Every state with a benefits-based assessment applies it to benefits paid on all workers' compensation insurance policies in existence at the time of enactment**. Those states do not, as the Insurers suggest Louisiana should, apply it only to insurance policies written after the statute's effective date. E.g., Idaho Code § 72-327(b) & (c); Ind. Code § 22-3-3-13; Md. Code Ann., Labor & Employment § 9-806. Even the model laws make no exception for insurance policies written prior to enactment. Workmen's Compensation and Rehabilitation Law § 55(c), at 56 (1965); Workmen's Compensation and Rehabilitation Law § 55(c), at 694 (1974).

ARGUMENT

I. THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT'S OPINION IN THIS CASE CONFLICTS WITH THIS COURT'S DECISION IN EASTERN ENTERPRISES V. APFEL.

The Fifth Circuit opinion ("Fifth Circuit's Opinion") in this matter relies on Eastern Enterprises v. Apfel, 524 U.S. 498, 118 S.Ct. 2131, 2146 (1998), to hold that Act 188 violates the Takings Clause. There are at least two reasons why Eastern Enterprises does not support the Fifth Circuit's Opinion.

First, although this Court found a violation of the United States Constitution in Eastern Enterprises, **this Court did not find a violation of the Takings Clause**. The majority of opinions in Eastern Enterprises held that plaintiffs must first establish an independent property right before they can argue that the state has taken that right without just compensation. 118 S.Ct. at 2154-58 (Kennedy, J., concurring in judgment but dissenting as to Takings Clause); 118 S.Ct. at 2160-68 (Stevens, Souter, Ginsburg, and Breyer, JJ., dissenting); see also Parella v. Retirement Bd. of Rhode Island Employees' Retirement System, 173 F.3d 46, 58 (1st

Cir. 1999); District Intown Properties Ltd. Partnership v. District of Columbia, 198 F.3d 874, 886 (D.C. Cir. 1999). There is no independent property right at issue in this case; therefore, the Fifth Circuit Opinion conflicts with this Court's decision in Eastern Enterprises.

Second, the facts of Eastern Enterprises are completely different from the facts of this case. Thus, the four Justices who found a taking in Eastern Enterprises would not find a taking in this case.

A. Eastern Enterprises Cannot Be Used to Find a Violation of the Takings Clause in this Matter Because a Majority of the Court Requires an Impact to an Identifiable Property Interest or Fund, and There Is No Identifiable Interest or Fund Impacted in this Matter.

The Fifth Circuit's Opinion specifically relies on Eastern Enterprises to hold that Act 188 is unconstitutional because it violates the Takings Clause. However, this Court did not hold that the statute at issue in Eastern Enterprises violated the Taking Clause; to the contrary, a majority of this Court specifically found that the statute at issue **did not** violate the Takings Clause. Moreover, this Court has never held that a statute violates the Takings Clause unless the statute impacts an identifiable property interest. 118 S.Ct. at 2155 (Kennedy, J., concurring).

In Eastern Enterprises, the Court reviewed the constitutionality of the Coal Industry Retiree Health Benefit Act of 1992 ("Coal Act") under the Due Process and Takings Clauses. Five Justices held that the Takings Clause is not implicated where the statute at issue does not impact an identifiable property interest or fund. Justice Kennedy found the statute unconstitutional, but his opinion, based solely on the Due Process Clause, requires that a statute operate upon or alter an identifiable property interest before

the Takings Clause is implicated.[7] 118 S.Ct. at 2154. Justice Stevens, Justice Souter, Justice Ginsburg, and Justice Breyer also found that the Coal Act **did not** violate the Takings Clause. Id. at 2161. Those four justices also require a statute to impact a specific interest in physical or intellectual property before a Takings Clause issue is raised. Id. Thus, not only did a majority of the Court find that the Coal Act did not violate the Takings Clause, a majority of the Court held that an identifiable property interest must be impacted before a Takings Clause claim may be raised.

Act 188 does not impact a specific property interest or fund. Act 188 simply imposes an obligation to perform an act, the payment of a general assessment on workers' compensation benefits paid. The statute is indifferent as to how the regulated entity elects to comply or the property it uses to do so. App. B at 36a; compare 118 S.Ct. at 2154 (Kennedy, J., concurring). Thus, Act 188 cannot violate the Takings Clause. See also, U.S. v. Sperry Corp., 493 U.S. 52, 110 S.Ct. 387, 397 (1989).

B. The United States Courts of Appeal Are Split as to the Effect of this Court's Opinions in Eastern Enterprises.

The United States Courts of Appeals for the District of Columbia, Third, and Fourth Circuits held that Eastern Enterprises only applies to the Coal Act and only to parties in a "substantially identical position to Eastern Enterprises with respect to both the plurality and Justice Kennedy's concurrence." See Anker Energy Corp. v. Consolidation Coal Co., 177 F.3d 161, 170 (3rd Cir. 1999); Association of Bituminous Contractors, Inc. v. Apfel, 156 F.3d 1246, 1253-54 (D.C.Cir.1998); Unity Real Estate Co. v. Hudson, 178 F.3d 649, 659 (3rd Cir. 1999); Holland v. Big River Minerals Corp., 181 F.3d 597, 606 (4th Cir. 1999); see also U.S.

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[7]It is important to note that the Insurers cannot prevail under Justice Kennedy's analysis because the Insurers never raised a Due Process Clause claim in this matter.

v. Dico, Inc., 189 F.R.D. 536, 542 (S.D.Iowa 1999) (holding that the United States Courts of Appeals for the Eighth Circuit would rule that Eastern Enterprises only applies to the Coal Act).

However, the United States Court of Appeals for the Fifth Circuit held in this matter that the Takings Clause analysis of Eastern Enterprises applies to a non-Coal Act statute that only imposes a general financial assessment against a company without identifying a particular property interest or fund. The Fifth Circuit's Opinion in this matter is the only United States Court of Appeals decision to find a statute unconstitutional based upon the Takings Clause analysis in Eastern Enterprises. This Court should grant a writ of certiorari to resolve this circuit split.

II. THE INSURERS FAILED TO CARRY THEIR "SUBSTANTIAL BURDEN" IN CHALLENGING ACT 188 AS AN UNCONSTITUTIONAL TAKING.

Assuming for the sake of argument that the Takings Clause is applicable in this matter even though the Insurers have shown no impacted property right and have made no Due Process Clause claim, summary judgment in favor of the Insurers is still inappropriate. The Insurers bear a "**substantial burden**" in challenging Act 188 as an unconstitutional taking. See United States v. Sperry Corp., 493 U.S. 52, 60, 110 S.Ct. 387, 393-94, 107 L.Ed.2d 990 (1989). The State Officials respectfully suggest that the Insurers did not carry this substantial burden.

Government regulation often "curtails some potential for the use or economic exploitation of private property," Andrus v. Allard, 444 U.S. 51, 65, 100 S.Ct. 318, 326, 62 L.Ed.2d 210 (1979), and "not every destruction or injury to property by governmental action has been held to be a 'taking' in the constitutional sense," Armstrong v. United States, 364 U.S. 40, 49, 80 S.Ct. 1563, 1569, 4 L.Ed.2d 1554 (1960).

This Court has not developed any set formula for determining when economic injuries caused by public action must

be compensated by the government, rather than remain disproportionately concentrated on a few persons. See Eastern Enterprises, 118 S.Ct. at 2146. However, the Court has identified at least three relevant factors: (1) the economic impact of the regulation, (2) its interference with reasonable investment-backed expectations, and (3) the character of the government action. Id. (citing Kaiser Aetna v. United States, 444 U.S. 164, 175, 100 S.Ct. 383, 390, 62 L.Ed.2d 332 (1979)).

A. Context for analysis.

Takings Clause analysis **must** be conducted in the context of the prior decisions of the Court. See Eastern Enterprises, 118 S.Ct. at 2146. While the clause itself sounds absolute, the Court's opinions in Connolly v. Pension Benefit Guaranty Corporation, 475 U.S. 211, 106 S.Ct. 1018, 89 L.Ed.2d 166 (1986), and Concrete Pipe & Products of Cal., Inc. v. Construction Laborers Pension Trust for Southern Cal., 508 U.S. 602, 113 S.Ct. 2264, 124 L.Ed.2d 539 (1993), make clear that the legislature has considerable leeway to fashion economic legislation. The legislature may also impose retroactive liability to some degree, particularly where it is "confined to short and limited periods required by the practicalities of producing national legislation." Pension Benefit Guaranty Corporation v. R.A. Gray & Co., 467 U.S. 717, 731, 104 S.Ct. 2709, 2719, 81 L.Ed.2d 601 (1984) (internal quotation marks omitted). In addition, legislation is not unlawful solely because it upsets otherwise settled expectations. Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 96 S.Ct. 2882, 49 L.Ed.2d 752 (1976). Thus, the only possibility left open by the Court's decisions that legislation might be unconstitutional is if the legislation imposes **severe retroactive** liability on a **limited** class of parties that **could not have** anticipated the liability, **and** the extent of that liability is **substantially** disproportionate to the parties' experience. See Eastern Enterprises, 118 S.Ct. at 2149.

B. Act 188 Has No Adverse Economic Impact on the Insurers.

In finding a taking, the Fifth Circuit's Opinion relies on the Insurers' unsupported contention that they never received a benefit from the Fund. App. A at 5a, 12a, 15a, 16a, and 17a. However, summary judgment in favor of the Insurers is clearly inappropriate because the Insurers failed to carry their substantial burden that the extent of their liability was substantially disproportionate to their experience. Not only is there no taking, the Insurers have received a windfall as a result of the Fund.

1. The Insurers failed to carry their substantial burden: the Insurers received premiums even though the Fund reimbursed the benefits.

The Fund's enactment in 1974 did not expand or alter the scope of coverage of the Insurers' workers' compensation insurance policies. La. Rev. Stat. § 23:1371(B). The Insurers' have always been contractually obligated to provide workers' compensation benefits regardless of whether the injury was an original injury, second injury, third injury, etc. After the Fund was enacted, however, whenever an Insurer paid benefits for injuries which are "second injuries," the Insurer was reimbursed by the Fund.

There was another change created by the Fund. After the Fund was enacted, insured employers not only paid insurance premiums to the Insurers, they also paid a Fund assessment surcharge to the Insurers. Because the scope of coverage was not increased by the Fund, the premiums should have been reduced by the amount of the surcharge because the Insurers were no longer ultimately liable for "second injury" benefits for the following year. **If the premiums were not reduced by the amount of the Fund assessment surcharge, the Insurers received a windfall as to that portion of the premium that was supposed to pay "second injury" benefits for the following year.**

Peter S. Barth, the Insurers' expert, submitted several affidavits in support of the Insurers' motion for summary judgment. In his August 15, 1996 affidavit, Barth states the general proposition that insurance companies collect lower premiums in states with second injury fund's. Barth, however, does not make any statement about the Insurers lowering premiums in Louisiana. Mr. James Campbell, the Second Injury Board Director, testified in his October 3, 1996 affidavit that there was **no** evidence that the Insurers ever lowered their premiums in Louisiana to account for the Fund assessment. App. E at 57a. Barth's October 12, 1996 affidavit argues with nearly every statement in Mr. Campbell's affidavit; however, Barth never even attempted to contest the fact that there was **no** evidence that the Insurers ever lowered their premiums in Louisiana.

Thus, the primary premise of the Fifth Circuit's Opinion, that the Insurers never benefitted from the Fund, is unsupported by the Insurers and is specifically disputed by the State Officials. App. C at 39a; App. E at 57a. The Insurers failed to present any evidence to support that element of their case. Thus the district court was correct in granting summary judgment for the State Officials. At the very least, the facts are in dispute; therefore, summary judgment in favor of the Insurers is inappropriate.

2. The Insurers failed to carry their substantial burden: the Insurers were able to pocket "reserves" when the fund was created.

There is typically a long gap, or "tail," between the date of a policy's issuance (and the premium paid) and the date when a claim is paid under that policy. App A at 6a, n.1. Occupational diseases such as asbestosis with long latency periods are one reason for a tail. Id. Workers suffering from these diseases might not file a claim until years or decades after exposure. Thus, a claim filed by a worker today might be covered by policies written decades in the past. **The concept of the "tail" is vital to this case because it is solely the assessment of the tail (specifically benefits paid after**

1995) of the Insurers' pre-1995 policies that the Insurers claim violates the Takings Clause.[8]

Insurance companies anticipate "tails" when they set the price for insurance policy premiums. Insurance companies charge sufficient premiums for each insurance policy to cover claims not only during the year of issuance but also the tail. The part of the premiums used for tails are usually accounted for as "reserves" although there is no specific fund for reserves for any particular policy or group of policies. Insurance companies plan the reserves so that they are sufficient to pay claims made on the policy in subsequent years.

Prior to the Fund, part of the premiums received by the Insurers was paid to cover the risk of paying "second injury" benefits. Part of these "second injury" benefits' premiums were accounted for as reserves to pay future "second injury" benefits. After the Fund was created, however, "second injury" benefits were paid by the Fund, not by the Insurers. Thus, the Insurers received a windfall. They were able to pocket money they had "reserved" prior to 1974 for "second injury" benefits' payable after 1974. The Insurers received a windfall for every dollar paid by the Fund for "second injury" benefits' claims on policies written before the Fund's creation.

For example, assume a worker discovers after the Fund's creation that the worker has a "second injury" occupational disease with a long latency period, such as asbestosis, that is covered by a policy written by an Insurer **before** the Fund was created. The worker's employer paid a premium to the Insurer for that policy, and part of the premium was paid to cover that claim. However, because the claim arose after the Fund's creation, the claim will be paid by the Fund, not the Insurer. Thus, the Insurer receives a windfall; it gets to keep the money it had "reserved."

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[8]In this Petition, the term "tail" shall refer to benefits or claims paid after the year covered by the policy.

The Insurers complain about the Fund's affect on the tail of their pre-1995 policies, but as stated above, they have benefitted from the Fund's affect on the tail of their pre-1974 policies. Clearly, there is proportionality between the Insurers' post-1995 liability under Act 188 and their experience as a result of the post-1974 windfall. Thus, the Insurers cannot show that their liability is substantially disproportionate to their experience. Moreover, the Insurers' windfall in 1974 came in one large lump sum, thereby giving the Insurers at least 20 years to invest the money before Act 188.

3. Eastern Enterprises is distinguishable from this case because the Coal Act imposed a severe economic impact upon Eastern Enterprises that was not proportional with its experience.

The Coal Act imposed a $50 to $100 million financial burden upon Eastern Enterprises. That impact is far greater than the burden imposed on all 41 of the Insurers **combined**. In addition, the financial burden had no proportionality to Eastern Enterprises' experience for at least three reasons. First, Eastern Enterprises left the coal industry before benefit plans similar to the Coal Act benefit plan had been established. Second, Eastern Enterprises left the coal industry long before the enactment of the Coal Act. Third, the Coal Act did not attempt to correlate Eastern Enterprises' business activity with the benefits Eastern Enterprises was required to pay.

Five justices in Eastern Enterprises found that Eastern Enterprises had left the coal business long before benefit plans similar to the Coal Act had been signed. 118 S.Ct. at 2152; 118 S.Ct. at 2159 (Kennedy, J., concurring). Thus, those justices held that it was unconstitutional to enact legislation holding Eastern Enterprises responsible for providing those benefits. This case is at the opposite end of the spectrum. Neither the Fund nor Act 188 created the obligation to provide "second injury" benefits. Rather, the Insurers themselves signed contracts creating the obligation.

Moreover, the Insurers signed the contracts providing "second injury" benefits long before Act 188 was enacted in 1995 and long before the Fund was created in 1974.

Eastern Enterprises ceased coal mining operations in 1965, almost **30 years** before the Coal Act was enacted. 118 S.Ct. at 2150. In contrast, the Insurers did not leave the insurance industry 30 years before Act 188 was enacted. The Insurers are still in the insurance industry today. More importantly, Act 188 does not assess the Insurers for their acts 30 years ago. It assesses the Insurers based upon the benefits they paid in the immediately preceding year.

The Coal Act did not assess Eastern Enterprises for benefits based upon the injuries or exposures an employee suffered while employed by Eastern Enterprises. 118 S.Ct. at 2152-53. Moreover, the Coal Act did not assess Eastern Enterprises based upon the amount of time an employee worked for Eastern Enterprises. The amount assessed against Eastern Enterprises resembled a calculation "made in a vacuum." 118 S.Ct. at 2150. As the Court stated:

> Thus, unlike the pension withdrawal liability upheld in *Concrete Pipe* and *Connolly*, the Coal Act's scheme for allocation of Combined Fund premiums is not calibrated either to Eastern's past actions or to any agreement—implicit or otherwise—by the company.

Id. at 2152. Conversely, Act 188's assessment is not "made in a vacuum." It is specifically calibrated to the benefits paid by each Insurer each year on active insurance policies each company voluntarily wrote upon risks they agreed to cover as part of a profit-making business that they are still engaged in today.

C. Act 188 Does Not Interfere with Reasonable Investment-backed Expectations.

Act 188 does not interfere with reasonable investment-backed expectations for at least three reasons: (1) Act 188 fulfills all reasonable investment-backed expectations; (2) the Insurers should have anticipated the change from premiums-based to benefits-based; and (3) the insurance industry is one of the most, if not the most, heavily regulated industries.

1. Act 188 fulfills all reasonable investment-backed expectations.

As discussed in section II.B.1. of this Petition, the Insurers provided no evidence to support their claim that they reduced premiums in the amount of the Fund assessment. Even if the Insurers did reduce their premiums to account for the assessment, however, Act 188 still fulfills their reasonable investment-backed expectations. For every assessment dollar the Insurers paid into the Fund, they have received an equivalent reimbursement in the following year. They never paid for anything more, and they never received anything less. **Thus, the Insurers received exactly what they paid for. What they seek in this lawsuit is to get something for free. The Insurers want to get reimbursed after 1995 without paying assessments after 1995.**

This is best illustrated through example. The Fund assessment paid by the Insurers in December of 1989, was paid back to the Insurers in 1990 in the form of reimbursements. The Fund assessment paid by the Insurers in December of 1990, was paid back to the Insurers in 1991 in the form of reimbursements. There was no Fund reserve to carry the 1990 assessments over to future years. The Fund could not and did not retain any 1990 assessments for 1992 or beyond. The assessments paid into the Fund were paid out every year in reimbursements.

The Insurers unilaterally expect that an assessment based upon premiums for policies written in 1990 somehow entitles them

to reimbursement for a claim made in 1999, merely because the claim arises out of the 1990 insurance policy. However, the only payment the Insurers made for reimbursement in 1999 was the Fund assessment paid in December 1998, an assessment which the Insurers seek to enjoin in this lawsuit.

Contrary to the Insurers mistaken belief, the premiums-based assessment paid by them prior to 1995 has no similarity to an insurance policy premium. Premiums are priced in an amount sufficient to cover the long "tail" of future claims or risks. The assessment was never priced or calculated to pay reimbursements beyond the immediately subsequent year. As Judge Parker found when he denied the Insurers' Motions for Summary Judgment:

> **It bears repeating that the Second Injury Fund is not insurance; it was never underwritten as such and assessments paid by plaintiffs were never intended to be considered in any sense a "premium" payment for insurance. The Fund was and is a new fund each year; that is, the total amount of benefits to be paid for the next year is estimated and the assessment necessary to pay those benefits in that year is made. Thus, each fund year stands on its own bottom.**

App. B at 35a (emphasis added). In short, the Insurers never paid for coverage of the post-1995 "tails" of their insurance policies with pre-1995 assessments, and that is precisely what Act 188 does – it assesses the post-1995 "tails" of the Insurers' pre-1995 policies.

2. The Insurers should have anticipated a change from a premiums-based assessment to a benefits-based assessment.

As the Insurers admitted in their brief to the Fifth Circuit:

> In this case, plaintiffs do not contend that they could not reasonably have anticipated a change in the [Fund] assessment formula from a premium-based method to a benefits-based one. Other states have used the benefits-based approach.

There are many other reasons why the Insurers should have anticipated a change from a premiums-based assessment to a benefits-based assessment: (1) the Insurers knew that the Fund had to be replenished each year; (2) the causes for legislative intervention were well-known when Act 188 was enacted; and (3) the OWCA assessed the Insurers through a benefits-based assessment for 12 years prior to Act 188.

The Insurers go on to say, "What plaintiffs could not have foreseen is that Louisiana not only would make such a change but would implement it *retroactively*, . . ."[9] By this statement, the Insurers ignore that every state that enacted a benefits-based assessment applied it "retroactively." Even the Insurers' expert, Peter Barth, notes that at the time Louisiana created the Fund, the 1965 and 1974 model laws, the 1972 Report, and the National Commission on State Workmen's Compensation Laws (of which Peter Barth was the Executive Director) recommended benefits-based assessments. Both the Model Laws and the laws of the states that use benefits-based assessments assess "retroactively"; they assess benefits paid on all policies, not just policies written after the Fund's creation.

In addition, the Insurers' expert admits that benefits-based systems are common. Moreover, Louisiana has funded the OWCA

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[9]The remainder of the Insurers' quote is: "thereby repudiating its prior commitment that SIF funding would be cost neutral to insurers." There was never any written or verbal commitment by Louisiana that the Fund would be cost-neutral to the Insurers. (Indeed, as set forth above, the Fund provided the Insurers with a windfall.) If there was such a commitment, the Insurers surely would have sued on it.

through a benefits-based assessment since 1983. App. E at 50a; see also, La. Rev. Stat. § 23:1291.1. The Insurers' argument that they had insufficient or inadequate notice that Louisiana might convert to a benefits-based system completely ignores both history and their own expert.

3. The insurance industry is heavily regulated.

The insurance industry is heavily regulated. California State Auto. Ass'n Inter-Insurance Bureau v. Maloney, 341 U.S. 105, 71 S.Ct. 601, 95 L.Ed. 788 (1951) (State power to regulate insurance "is broad enough to take over the whole business, leaving no part for private enterprise [and] the State may therefore hold its hand on condition that local needs be serviced by the business.") Moreover, the Fund itself is heavily regulated. Over the years, the Legislature has constantly adjusted the statutory cap on the maximum allowable assessment percentage. See 1985 Louisiana Acts No. 697, § 1, (raising assessment from 1% to 1½%); 1988 Louisiana Acts No. 997, § 1 (raising assessment from 1½% to 2%); 1992 Louisiana Acts No. 862, § 1, (raising assessment from 2% to 2¾%). Every year the board must determine the percentage which will be actually assessed. In addition, the statute sets forth precise procedures for claiming reimbursement and appealing decisions of the board.

Because the industry is heavily regulated, the industry participants should and do expect reasonable alterations to the laws that regulate it. The change enacted by Act 188 is minimal. Act 188 only altered the method for measuring each participants' activity to determine the amount of the assessment. The basic program remained the same.

In California State Auto, the Court upheld a law requiring California insurers to accept an equitable apportionment of automobile drivers who were unable to obtain automobile insurance. The plaintiff in that case was an insurer who had withdrawn from a voluntary plan designed to achieve the same

goal. When the State enacted the mandatory plan, the insurer refused to subscribe to it. In finding that the State could require the insurer to accept a line of business which may not have been profitable, the Court stated:

> The case in its broadest reach is one in which the state requires in the public interest each member of a business to assume a pro rata share of a burden which modern conditions have made incident to the business. It is therefore not unlike *Noble State Bank v. Haskell* which sustained a state law assessing each state bank for the creation of a depositors' guaranty fund. What was there said about the police power—that it 'extends to all the great public needs' and may be utilized in aid of what the legislative judgment deems necessary to the public welfare--is peculiarly apt when the business of insurance is involved—a business to which the government has long had a 'special relation.' Here, as in the banking field, the power of the state is broad enough to take over the whole business, leaving no part for private enterprise.

Id. 341 U.S. at 109-10 (citations omitted.) The Court further stated that, "Appellant's business may of course be less prosperous as a result of the regulation. That diminution in value, however, has never mounted to the dignity of a taking in the constitutional sense." Id. at 111.

Thus, the assessment can be viewed as merely a cost of engaging in the insurance business in Louisiana. Such regulation in the insurance industry has been routinely upheld. See Northwestern National Life Ins. Co. v. Riggs, 203 U.S. 243, 27 S.Ct. 126, 51 L.Ed. 168 (1906) (limitation of defenses); Whitfield v. Aetna Life Ins. Co., 205 U.S. 489, 27 S.Ct. 578, 51 L.Ed. 895 (1907) (same); National Union Fire Ins. Co. v. Wanberg, 260 U.S. 71, 43 S.Ct. 32, 67 L.Ed. 136 (1922) (limiting the time for rejection of hail insurance policies); Life & Casualty Ins. Co. v.

McCray, 291 U.S. 566, 54 S.Ct. 482, 78 L.Ed. 987 (1934) (additional recovery for failure to pay on demand); State Farm Mutual Automobile Ins. Co. v. Duel, 324 U.S. 154, 65 S.Ct. 573, 89 L.Ed. 812 (1945) (reserve requirements).

In Liberty Mutual Insurance Co. v. Whitehouse, 868 F.Supp. 425 (D.R.I. 1994), the State of Rhode Island enacted a statute requiring insurance companies to pay annual cost-of-living adjustments (COLA) to certain employees already receiving benefits. The district court upheld the statute, noting that plaintiffs were engaged in a highly regulated industry and could have no reasonable expectation that their rates would be immune from future restrictions. Id. at 431. The court found the statute was justifiable as an appropriate means of achieving a significant and legitimate public purpose. Id. at 432.

4. Eastern Enterprises is distinguishable from this case because the Coal Act substantially interfered with Eastern Enterprises reasonable investment-backed expectations.

The Court found that the Coal Act substantially interfered with Eastern Enterprises reasonable investment-backed expectations:

> The Act's beneficiary allocation scheme reaches back 30 to 50 years to impose liability against Eastern based on the company's activities between 1946 and 1965. Thus, even though the Act mandates only the payment of future health benefits, it nonetheless "attaches new legal consequences to [an employment relationship] **completed** before its enactment." *Landgraf v. USI Film Products*, 511 U.S. 244, 270, 114 S.Ct. 1483, 1499, 128 L.Ed.2d 229 (1994).

Eastern Enterprises, 118 S.Ct. at 2151 (emphasis added). In contrast, the relationship between the Insurers and their insureds is not completed. The Insurers are still paying benefits upon insurance policies which are still in effect. It is those benefits which are being assessed. The Insurers' insureds paid premiums specifically to insure that their relationship with the Insurers continued into the future. Those insureds would be surprised to learn that their insurers are arguing that their relationship ended.

In addition, in analyzing Eastern Enterprises' reasonable investment-backed expectation, the Court examined the government's involvement in the coal industry at the time of Eastern Enterprises' operations. At the time that Eastern Enterprises was involved in the coal industry, the coal industry was not heavily regulated. As the Court stated:

> Nor would the pattern of the Federal Government's involvement in the coal industry have given Eastern "sufficient notice" that lifetime health benefits might be guaranteed to retirees several decades later.

Id. at 2152. Moreover, during the years in which Eastern Enterprises employed miners, retirement and health benefits were far less extensive, were unvested, and were fully subject to alteration or termination. Id.

The insurance industry, in contrast, is and has been heavily regulated at least since 1974. Moreover, by the terms of the insurance contracts they signed, the Insurers had clear notice that benefits were "guaranteed" to second injury claimants. Act 188 did not alter the requirements for workers' compensation benefits in any manner. More importantly, Act 188 did not change the fact that the benefits were financed by annual assessments upon insurers and self-insured employers based upon their workers' compensation activity in the previous year. The only thing that changed was the basis for measuring that activity.

D. The Character of Act 188 Supports its Constitutionality.

As Judge Parker found, "This is not a taking that deprives the plaintiffs of their property but rather is 'a public program that adjusts the benefits and burdens of economic life to promote the common good.'" App. B at 31a (quoting Connolly, 475 U.S. at 225).

1. Act 188 was necessary and is fair.

The Statement of the Case provides overwhelming reasons why Act 188 was necessary. There are at least three additional reasons why equitable principles support the constitutionality of Act 188.

First, Act 188 is fair because it requires the Insurers to honor their contractual promises to their insureds. The Insurers voluntarily agreed to insure the risks of second injuries. The Insurers' received premiums from their insureds based upon those policies. The Insurers seek to have a portion of the risk they agreed to insure, now revert back to their insureds. If the Insurers do not pay the Fund assessment, the cost of second injuries arising out of pre-1995 policies will revert as a burden upon the 91,000-plus employers of Louisiana. The employers of Louisiana will be paying twice for second injuries: past insurance premiums to the Insurers to cover the current cost of second injuries, and present assessments to the Fund to cover the current cost of second injuries. Moreover, it will be through no fault on their part. It will be solely due to the Insurers' unilateral actions.

Second, Act 188 is fair because it prevents the Insurers from receiving a windfall. The Insurers contractually agreed to provide "second injury" benefits. Therefore, if they seek reimbursement from the Fund for paying those benefits, they should contribute to the Fund in an amount equivalent to their use of the Fund. A benefits-based assessment is a fair means of

enforcing contribution to the Fund, thereby preventing a windfall to any entity.

Third, Act 188 is fair because it promotes stability in the workers' compensation insurance market. Without Act 188, insurance companies are induced to leave the market because of the windfall available by shifting a portion of their risk, second injuries, to remaining insurance companies and employers.

The Insurers suggested a premiums-based assessment for insurers and a benefits-based assessment for self-insured employers. However, even a partial premiums-based system is inequitable because premiums may not accurately reflect workers' compensation activity. For example, a large insured employer with a high deductible and consequently small premium may have a smaller premiums-based assessment than the benefits-based assessment of a small self-insured employer even though the large employer has greater workers' compensation activity. In addition, a hybrid system is inequitable because it uses two different time references to assess similarly situated parties.

The Insurers also suggested a "prospective" approach – the Fund assess benefits paid only on policies written after 1995. However, a "prospective" approach would be unfair. The Fund pays benefits for second injuries that are covered by pre-1995 insurance policies. To assess benefits paid only on post-1995 policies would completely disconnect the liability for second injury benefits from an entity's actual loss history. There would be no proportionality between the assessment paid and the experience with the Fund.

The Takings Clause and fundamental fairness requires that the extent of a party's liability be substantially proportionate to the party's experience. Because of the "tail," insurers do not pay benefits only in the year an insurance policy is written. Therefore, there can be no proportionality with a "prospective" assessment. Only an assessment on **all** workers' compensation policies is proportional and, therefore, fair.

2. Eastern Enterprises is distinguishable from this case because the Coal Act was unfair.

The Court found that the Coal Act implicated fundamental principles of fairness underlying the Takings Clause because it "singles out certain employers to bear a burden that is substantial in amount, based on the employers' conduct far in the past, and unrelated to any commitment that the employers made or to any injury they caused,..." Eastern Enterprises, 118 S.Ct. at 2153. The Court held, "Eastern cannot be forced to bear the expense of lifetime health benefits for miners based on its activities decades before those benefits were promised." Id.

In sharp contrast, the Fund assessment was based upon the general understanding of all participants that any insurer or self-insured employer would be reimbursed for second injury benefits from a fund to which the insurers and self-insured employers would contribute annually based upon their activity in the workers' compensation industry. **Those second injury benefits are not something newly created by Act 188.**

That the Insurers are contributing to this problem is another fact which distinguishes this case from Eastern Enterprises. In Eastern Enterprises, the Court noted that the Coal Act was intended to remedy a problem caused by the 1974 benefit plan for miners:

> As more and more coal operators abandoned the Benefit Plans, the remaining signatories were forced to absorb the increasing cost of covering retirees left behind by exiting employers. A spiral soon developed, with the rising cost of participation leading more employers to withdraw from the plans, resulting in more onerous obligations for those that remained.

Id. at 2140. The Court made special mention of the fact that Eastern Enterprises did not contribute to that problem. Id. at 2150.

Eastern Enterprises had exited the coal mining industry long before the 1974 benefit plan or the 1978 changes. In sharp contrast, the Insurers are still in the insurance industry, and they were contractually bound to provide the benefits long before they left Louisiana.

III. CONCLUSION

A majority of this Court, Justices Stevens, Kennedy, Souter, Ginsburg, and Breyer, agrees that there can be no violation of the Takings Clause without an impact to an identifiable property interest or fund. However, the statute challenged in this lawsuit does not impact any identifiable property interest or fund. Act 188 merely imposes a general assessment upon the Insurers based upon the benefits they pay in a particular year. Thus, Act 188 does not violate the Takings Clause. In addition, because the Insurers failed to raise a Due Process Clause claim, the Fifth Circuit improperly relied on Eastern Enterprises to strike down Act 188 as it applies to the Insurers.

Equally important, the four members of the Court in Eastern Enterprises who found that the Coal Act violated the Takings Clause, Chief Justice Rehnquist and Justices O'Connor, Scalia, and Thomas, would not find that Act 188 violates the Takings Clause. The Insurers failed to carry their substantial burden because they failed to present any evidence that: (1) the extent of their liability was substantially disproportionate to their experience, (2) they never received any benefit from the Fund, and (3) they lowered their premiums in Louisiana. Act 188 assesses the Insurers on benefits paid in the present pursuant to contracts to provide benefits that the Insurers voluntarily entered as part of a profit-making business that they are still engaged in today.

Therefore, the Court should grant the writ of certiorari to review the Fifth Circuit's Opinion in this matter because the Fifth Circuit's Opinion conflicts with relevant decisions of this Court on both the proper applicable analysis and the application of that analysis to the facts of this matter. In so doing, the Fifth Circuit

becomes the first United States Court of Appeals to use the Takings Clause to strike down a regulatory statute that does not impact a specific property interest or fund.

Respectfully submitted:

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[Filed September 15, 2000]

No. 99-30475

UNITED STATES FIDELITY & GUARANTY CO., et al., *Plaintiffs,*	)
UNITED STATES FIDELITY AND GUARANTY CO; FIDELITY & GUARANTY INSURANCE CO; FIDELITY & GUARANTY INSURANCE UNDERWRITERS, INC; ARGONAUT INSURANCE COMPANY; ARGONAUT MIDWEST INSURANCE COMPANY; ARGONAUT SOUTHWEST INSURANCE COMPANY; COMMERCIAL UNION INSURANCE COMPANY; AMERICAN CENTRAL INSURANCE; AMERICAN EMPLOYERS' INSURANCE COMPANY; EMPLOYERS FIRE INSURANCE COMPANY; THE NORTHERN ASSURANCE COMPANY OF AMERICA; UNITED STATES FIRE INSURANCE COMPANY; NORTH RIVER INSURANCE COMPANY; INSURANCE COMPANY OF NORTH	)

AMERICA; BANKER'S STANDARD)
INSURANCE COMPANY; CENTURY)
INDEMNITY CO; CIGNA FIRE)
UNDERWRITERS INSURANCE)
COMPANY; CIGNA INSURANCE CO;)
CIGNA PROPERTY & CASUALTY)
INSURANCE COMPANY; CIGNA)
SPECIALITY INSURANCE COMPANY;)
INDEMNITY INSURANCE COMPANY)
OF NORTH AMERICA; PACIFIC)
EMPLOYERS INSURANCE COMPANY;)
HARTFORD ACCIDENT AND CASUALTY)
COMPANY, HARTFORD CASUALTY)
INSURANCE COMPANY; HARTFORD)
FIRE INSURANCE COMPANY; HARTFORD)
INSURANCE COMPANY OF THE)
MIDWEST; HARTFORD INSURANCE)
COMPANY OF THE SOUTHEAST;)
HARTFORD UNDERWRITERS)
INSURANCE COMPANY; TWIN CITY)
FIRE INSURANCE COMPANY;)
TRAVELERS INSURANCE COMPANY;)
TRAVELERS INDEMNITY COMPANY OF)
AMERICA; THE TRAVELERS INDEMNITY)
COMPANY; THE TRAVELERS INDEMNITY)
COMPANY OF CONNECTICUT; THE)
TRAVELERS INDEMNITY COMPANY OF)
ILLINOIS; CHARTER OAK FIRE)
INSURANCE COMPANY; PHOENIX)
INSURANCE COMPANY; AETNA CASUALTY)
& SURETY COMPANY; CIGNA INDEMNITY)
INSURANCE COMPANY; LIBERTY)
MUTUAL INSURANCE COMPANY;)

LIBERTY MUTUAL FIRE INSURANCE COMPANY; LIBERTY INSURANCE CORPORATION,
Plaintiffs-Appellants,

v.

W. FOX MCKEITHEN, etc., et al.,
Defendants,

W. FOX McKEITHEN, Louisiana Secretary of State; KEN DUNCAN, Louisiana State Treasurer; GLYNN VOISIN, Judge, Director of Workers' Compensation of Louisiana; JAMES H. BROWN, Louisiana Commissioner of Insurance; MADLYN B. BAGNERIS, Secretary of Social Services of Louisiana, in their official capacities as members of the Louisiana Workers' Compensation Second Injury Board; CHRIS WEAVER, Acting Secretary, Louisiana Department of Labor,
Defendants-Appellees.

September 15, 2000, Decided

JUDGES:
Before JONES, DUHE, and WIENER, Circuit Judges.

OPINION

EDITH H. JONES, Circuit Judge

Plaintiffs, United States Fidelity & Guaranty Company and various other private insurance companies, appeal the district court's summary judgment upholding a Louisiana statute that altered the funding formula for the Louisiana Workers' Compensation Second Injury Fund. Because, as applied to the plaintiffs, the statute in question violates the Takings Clause of the United States Constitution, we REVERSE the judgment and REMAND for further proceedings.

I. BACKGROUND

In 1974, the Louisiana legislature established the Workers' Compensation Second Injury Fund ("SIF"). See 1974 La. Acts, No. 165, § 1 (the "1974 Act"). The SIF's stated purpose was to encourage the hiring and retention of disabled workers. Under the previous workers' compensation system, an employee's current employer was responsible for payment of disability benefits even though the worker's disability was partly attributable to a prior accident or disability not involving the current employer. As a result, an employer faced higher insurance costs when hiring a previously disabled worker than it would for an able-bodied worker, and the hiring of previously-injured employees was concomitantly discouraged.

The SIF removed from the ordinary course of insurance an employer's hiring of previously-injured workers. Under the SIF, if an employer became liable to pay

compensation to a disabled worker as a result of a second injury, the SIF reimbursed the employer (if the employer was self-insured) or the employer's workers' compensation insurer (if the employer was insured) for benefits paid to the employee. As designed, the SIF was cost-neutral to workers' compensation insurers while spreading the costs of second injury benefits among all employers in the State of Louisiana. This policy was implemented in two ways. First, when an injured worker filed a second injury claim with an insurer, the insurer paid the claim but obtained reimbursement from the SIF. The insurer was thus an intermediary, with the SIF serving as the ultimate payor of benefits. Claims for serial injuries no longer formed part of an employer's loss profile on which its worker's compensation premiums were directly based.

Second, the insurer acted as a conduit through which the SIF passed on reimbursement costs and administrative expenses to insured employers. (The SIF assessed self-insured employers directly.) Under the 1974 Act, insurers were assessed a legislatively-fixed percentage of workers' compensation insurance premiums collected during the applicable year. See La. Rev. Stat. § 23:1377(B)(1974). Louisiana regulators interpreted the 1974 Act to allow insurers to pass these assessments on to employers by including them in the "expense component" of workers' compensation insurance rates. By including the assessment in the premiums billed to insureds, the insurers were reimbursed by employers, on a dollar-for-dollar basis. The assessments were ultimately borne by the employers proportionately, and the State of Louisiana thus avoided the administrative difficulties of collecting small assessments from thousands of insured employers. Insurers also collected lower premiums in

recognition of the fact that they no longer covered the costs of workers' second injury claims. This system assured that insurers bore none of the SIF's costs and received no net benefit from the SIF.

In 1995, the Louisiana legislature enacted Act 188, which amended the 1974 Act. See 1995 La. Acts, No. 188 ("Act 188"), codified at La. Rev. Stat. § § 23:1371-1378. Act 188 did not change the purpose or organization of the SIF, but it did change the method of assessing insurers' annual contributions to the SIF. Instead of basing assessments on a percentage of premiums collected in Louisiana, Act 188 moved to a percentage of workers' compensation benefits paid by the insurer or self-insured in the previous calendar year. While the previous system based assessments on an insurer's current volume of transactions -- specifically, premiums collected under policies written contemporaneously with the assessment -- Act 188 predicates assessments on the insurer's volume of business written in earlier years.[1]

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[1] According to the plaintiff insurance companies, there is typically a long gap, or tail, between the date of a policy's issuance and the date when a claim is paid under that policy. This "tail" exists for three reasons. First, workers suffering total or partial permanent disability are entitled to benefits for some years during which they would have had, but for the injury, an earnings capacity. Second, if an injury is fatal, workers' surviving family members are entitled to death benefits -- the worker's spouse until death or remarriage and any children until they reach the age of majority. Finally, occupational diseases such as asbestosis have long latency periods, and workers suffering from these diseases might not file claims until years or decades after exposure to the asbestosis or other disease-causing substance.

In addition to changing the SIF's assessment formula, Act 188 was made retroactive to insurance policies written before the Act's passage. Thus, Act 188 applies to any policy written before its effective date[2] if that policy resulted in the payment of benefits after the effective date. Act 188 was also made expressly applicable to workers' compensation insurers who, prior to the Act's passage, had withdrawn from the Louisiana market or had substantially reduced their underwriting in the state.[3]

The plaintiffs represent the class of insurers that, prior to 1995, withdrew from the Louisiana market or substantially reduced their underwriting in the state.[4] In April 1996, they initiated this action, alleging that application of Act 188 to pre-enactment insurance contracts violated the Takings

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[2] Act 188 was effective June 12, 1995. La. Rev. Stat. § 23:1377.

[3] Act 188 provides that "any property and casualty insurer that has discontinued writing workers' compensation insurance in this State . . . shall continue to be liable for payment of any assessment to the [SIF] on account of any benefits paid." La. Rev. Stat. § 23:1377(C)(2).

[4] Two of the plaintiff families of affiliated companies, United States Fidelity & Guaranty Company and Crum & Forster (d/b/a U.S. Fire and North River) effectively withdrew from the Louisiana market. The remaining plaintiffs substantially reduced their underwriting in the State. For example, the plaintiffs offered evidence that one insurer reduced its premium volume from $ 62 million to $ 2 million from 1990 to 1994. Another insurer reduced its volume from $ 88 million to $ 5 million during the same period, and another reduced its volume from $ 74 million to $ 8 million.

Clause, the Contract Clause, and the Equal Protection Clause of the U.S. Constitution. They named as defendants, in their official capacities, the members of the Louisiana Workers' Compensation Second Injury Board (the "Board"), the Louisiana Secretary of Labor, and the State's Commissioner of Insurance (collectively, the "state officials"), all of whom are responsible for implementing or enforcing Act 188.[5] The complaint sought declaratory and injunctive relief.

The parties filed cross-motions for summary judgment, and the case was referred to a magistrate judge, who recommended that the state officials' motion be granted on the Contract Clause and Equal Protection claims and that the plaintiffs' motion be granted on the Takings Clause claim. After timely objections by the parties, the district court granted summary judgment in favor of the state officials on all claims and dismissed the case.

Plaintiffs now appeal the disposition of their Contract Clause and Takings Clause claims.[6]

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[5] The complaint also named the Louisiana Attorney General as a defendant in his official capacity, but he was later dismissed by stipulation of the parties.

[6] We review the district court's grant of summary judgment *de novo*. *Voting Integrity Project, Inc. v. Bomer*, 199 F.3d 773, 774 (5th Cir. 2000); *Norman v. Apache Corp.*, 19 F.3d 1017, 1021 (5th Cir. 1994). As the facts are uncontested, the questions before us are those of law, including characterizing the legal effect of the facts.

II. DISCUSSION

The Takings Clause of the Fifth Amendment provides: "Nor shall private property be taken for public use, without just compensation." U.S. Const. amend V.[7] The purpose of the Takings Clause is to prevent the government from "forcing some people alone to bear public burdens, which, in all fairness and justice, should be borne by the public as a whole." *Eastern Enterprises v. Apfel,* 524 U.S. 498, 522, 118 S. Ct. 2131, 2146, 141 L. Ed. 2d 451 (1998, (quoting *Armstrong v. United States,* 364 U.S. 40, 49, 80 S. Ct. 1563, 1569, 4 L. Ed. 2d 1554 (1960)).

This case does not present a classic taking in which the government directly appropriates private property for its own use. *See Eastern Enterprises,* 524 U.S. at 522. Rather, the alleged taking arises from an economic regulation -- a "public program adjusting the benefits and burdens of economic life to promote the common good." *Id.*, citing *Penn Central Transp. Co. v. New York City,* 438 U.S. 104, 124, 98 S. Ct. 2646, 2659, 57 L. Ed. 2d 631 (1978). The inquiry into a challenged regulation's constitutionality involves an evaluation of the "justice and fairness" of the government action. *Id. 524 U.S. at 523.* Although this inquiry involves no set formula and is necessarily *ad hoc* and fact intensive, the Supreme Court has identified three factors of "particular significance" to a regulatory takings clause analysis: (1) the

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[7] The Fifth Amendment applies to the states through the Fourteenth Amendment. *Williamson County Regional Planning Comm'n v. Hamilton Bank of Johnson City,* 473 U.S. 172, 105 S. Ct. 3108, 3111, 87 L. Ed. 2d 126 (1985).

economic impact of the regulation on the claimant; (2) the extent to which the regulation has interfered with reasonable investment-backed expectations; and (3) the character of the government action. *Id.* at 523, 524, citing *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224-25, 106 S. Ct. 1018, 1026, 89 L. Ed. 2d 166 (1986).

It must be acknowledged that a plaintiff bears a substantial burden in proving that government action inflicts an unconstitutional taking. *See United States v. Sperry Corp.*, 493 U.S. 52, 60, 107 L. Ed. 2d 290, 110 S. Ct. 387 (1989). Further, the complexity of the issue manifests itself in the variety of relevant Supreme Court decisions. *See, e.g., Eastern Enterprises,* 524 U.S. at 541-42 (KENNEDY, J., concurring in the judgment and dissenting in part and citing numerous cases). Nevertheless, a review of the justice and fairness of Act 188 in light of the three listed factors leads to the same conclusion reached by the magistrate judge: as applied to the plaintiffs' insurance contracts entered into before the law's effective date, Act 188 unconstitutionally takes the plaintiffs' property without just compensation.[8]

A. Economic Impact

In examining the economic impact of Act 188, not only the financial burden it imposes but also the proportionality between that burden and the insurers' experience with the SIF must be considered. *See Eastern*

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[8] Because we invalidate Act 188 as applied to plaintiffs under the Takings Clause, we will pretermit and express no opinion on the plaintiffs' Contract Clause claim.

Enterprises, 524 U.S. at 530. Additionally relevant are any parts of Act 188 by which plaintiffs can "moderate and mitigate" the economic impact. *Id.*, 524 U.S. at 527.

There is no doubt that Act 188 imposes a considerable, novel financial burden on the plaintiffs. Under the SIF funding scheme established by the 1974 Act, insurers paid a net amount of zero for claims made on the Second Injury Fund and collected SIF premiums from their insureds only to pass-through the SIF assessments. In contrast, Act 188 charges insurers based on benefits paid under insurance policies written before the law's effective date, and it affords these plaintiffs no means to recoup the charge. Insurers that have maintained a substantial presence in the Louisiana market can still pass the cost of these assessments to their insureds. But plaintiff insurers that have discontinued writing policies in Louisiana charge no ongoing premiums in the State through which the assessments can be passed. Likewise, plaintiff insurers that have substantially reduced their volume of business cannot, as a practical matter, pass the assessments through to employers; their reduced premium base would require uncompetitively high rates that would drive them out of the market.[9] The magistrate judge found that Act 188 cost the plaintiffs $ 5 million in 1995, and plaintiffs themselves estimate without contradiction that Act 188 will cost them $ 45 million in the future. These sums represent a substantial liability. *See Eastern Enterprises*, 524 U.S. at 529-32 (finding a substantial economic impact where the plaintiff had been

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[9] These plaintiffs' evidence that they would have to raise rates to noncompetitive levels to pass on the costs of the new assessments went uncontradicted by defendants.

assessed $ 5 million in one year and faced even greater future liabilities).

The defendants contend, however, that plaintiffs have suffered no negative impact because plaintiffs in 1995 received a total reimbursement benefit of over six million dollars thanks to Act 188. This is specious. The reimbursement touted by defendants did not cover the assessments now paid by the plaintiff insurers. Even after the passage of Act 188, insurers or self-insured employers continue to be reimbursed by the SIF for the benefits they have paid to reinjured workers. The fundamental structure of the SIF has not been altered, but the imposition of part of its cost upon insurers without opportunity for pass-through is new.

In essence, the State of Louisiana is the troll under the bridge, extracting money from businesses whose sole activity is sending money into the state. This amounts to a transfer of plaintiffs' assets to the state or to third parties for public use.

The newly-created liability reflects no proportionality to the plaintiffs' experience with the SIF. For over twenty years before Act 188, plaintiffs were an intermediary for the SIF. They collected assessments from employers and received SIF reimbursement for payment of second injury benefits. They received no net benefits and incurred no net costs. Defendants do not argue that the policy and purpose of the SIF have changed since its inception in 1974. But under Act 188, plaintiffs must make significant net contributions to the fund. Act 188 thus imposes costs on parties that never profited from the SIF.

Defendants argue that the plaintiffs are still receiving SIF reimbursement even though, if Act 188 is invalidated, they would no longer be paying assessments to SIF. Again, defendants ignore that, under both the 1974 and 1988 Acts, entitlement to reimbursement arises from payment of second injury benefits, not from assessments. The purpose of the SIF program has consistently been to remove the direct cost of serial injuries from the risk-adjusted insurance market and to replace it by pay-as-you go funding. Even the insurers that no longer do business in Louisiana incur no windfall from this program, as they receive no net profit from SIF reimbursements and never in the past collected premiums for the risk of second injuries.

Defendants also fail to show that plaintiffs could have mitigated or moderated the impact of Act 188. Act 188 offered no gradual phase-in period. If plaintiffs refuse to pay the assessments, they are subject to substantial penalties, including a civil penalty equal to 20 percent of the amount assessed but unpaid. Though defendants suggest that plaintiffs could choose to write more workers' compensation policies in the state, the mitigating measures must be found in the challenged regulation itself. *See Connolly,* 475 U.S. at 226 (finding that the challenged statute itself contained provisions by which the plaintiff could mitigate liability).

B. Interference with Reasonable Investment-Backed Expectations

Retroactivity is generally disfavored in the law. See *Eastern Enterprises,* 524 U.S. at 532, 118 S. Ct. 2131 at (citing *Bowen v. Georgetown Univ. Hospital,* 488 U.S. 204, 208, 109 S. Ct. 468, 469-70, 102 L. Ed. 2d 493 (1988)).

Retroactive legislation, as opposed to the prospective kind, can present more severe problems of unfairness because it can upset legitimate expectations and settled transactions. *See General Motors Corp. v. Romein,* 503 U.S. 181, 191, 112 S. Ct. 1105, 1112, 117 L. Ed. 2d 328 (1992).

The magistrate judge found that Act 188's retroactive application reached back at least twenty years to upset the plaintiffs' reliance on the cost-neutrality of the 1974 funding scheme. We agree.[10]

Defendants do not dispute the extent of the reach-back. Instead, they assert that the companies' alleged economic expectations are unreasonable because the insurance industry is heavily regulated and because the plaintiffs knew of the SIF's need for annual funding and knew that benefits-based assessments are prescribed in many other states.

None of these factors -- extensive regulation, SIF's pay-as-you-go status, or other states' policies -- made it objectively reasonable to expect that Louisiana would decide to shift the cost of funding the SIF from in-state employers to insurers who had withdrawn, wholly or partly, from writing insurance in Louisiana and who could not recoup the costs of this forced underwriting. While plaintiffs might have been on notice that there could be a change away from premium-based

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[10] The district court erred in finding that Act 188 did not operate retroactively. In changing the assessment formula for contracts written before its effective date, Act 188 attaches new legal consequences to past acts. This is the very definition of retroactivity. *See Landgraf v. USI Film Products,* 511 U.S. 244, 269 n. 23, 114 S. Ct. 1483, 1499 n. 23, 128 L. Ed. 2d 229 (1994).

assessments, there was no evidence that the plaintiffs should have suspected abandonment of cost-neutrality.[11] There was no evidence that the cost of financing the SIF was ever intended to be borne by insurers, that there existed any rationale or policy for imposing the cost on insurers, or that the state was contemplating shifting the burden of funding onto insurers.

And while the majority of states do not use the premium-based assessment method for their SIF's, and that method might have posed certain administrative problems for Louisiana, insurers could hardly have foreseen the retroactive imposition of a benefits-based method.

Finally, the mantra that insurance is a regulated industry will not cover all sins of retroactivity. The coal industry had been heavily regulated with respect to miners' health benefits, but the Supreme Court was not persuaded that the retroactive liability in Eastern Enterprises could have been anticipated. *See Eastern Enterprises,* 524 U.S. at 534-36. Here, Louisiana's abandonment of cost-neutrality has shifted onto these plaintiffs -- for the first time -- costs attributable to the SIF. Contrary to the state's contention, the insurers did

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[11] Indeed, if cost-neutrality is abandoned, Louisiana must afford insurers some way to recoup the costs of their underwriting of second injury claims. Otherwise, the state would be requiring the insurers to bear a burden imposed on no other part of society. Insurers could then easily decide to withdraw from the state en masse rather than accept this burden. It is not an accident that Louisiana thus decided to abandon cost-neutrality only as to a few insurers who had already substantially abandoned new underwriting there.

not have a stake in the SIF that would justify a reasonable expectation that they might be required to subsidize it. Insurers are only one tiny group among the employers who formerly shared the cost of the SIF. More important, because the fund was cost-neutral to them, they never received a net benefit from it. Except for reasons of administrative convenience, the SIF was intended to be a non-insurance-based compensation program. Regulation of the insurance business was actually extended in a novel way when Act 188 imposed non-reimbursable assessments on these plaintiffs.

In short, there was no pattern of conduct on the state's part that could have given the plaintiffs sufficient notice that cost-neutrality would end. *See Eastern Enterprises*, 524 U.S. at 498 (examining the government's pattern of involvement in the regulated field in order to determine whether plaintiff had sufficient notice of the challenged regulation).

The magistrate judge also found, and we agree, that the defendants failed to show an adequate justification for the retroactive application of Act 188. There are no indications in the law itself, in the legislative history, or in the record of this case that the SIF was financially insecure, or that employers were having trouble bearing the costs of operating the SIF. Defendants justified Act 188 by relying on evidence of administrative difficulties in computing premium-based assessments for self-insureds, but they do not explain how retroactive application of Act 188 helps to alleviate this problem.

C. Nature of the Government Action

The district court found that Act 188 was "a rational attempt by the state to impose the costs inherent in a certain type of business activity on those who have profited from the fruits of the business in question." This characterization, as has been repeatedly explained, is wrong. Insurers were perhaps the only party that did not benefit from the 1974 SIF funding scheme. Employers profited from the creation of the SIF because the costs of second-injury benefits were spread across all employers. Workers, especially disabled workers, profited because the SIF made it cheaper to hire them. The State of Louisiana profited because the SIF furthered state policy on the employment of disabled workers. But insurers did not profit from the SIF, though neither did they suffer any detriment.

The district court also erred in finding that Act 188 provides for "just compensation." Act 188 does not prohibit insurers from recovering the costs of assessments through the rate-making process, but the district court overlooked that plaintiffs cannot avail themselves of the rate-making process. As applied to the plaintiffs' pre-enactment contracts, the statute does not provide "just compensation."

The nature of the government action here is thus unusual. Without identifying a compelling problem, such as the financial insecurity of the SIF, the state enacted a solution that "singles out certain [parties] to bear a burden that is substantial in amount, based on the [parties'] conduct far in the past, and unrelated to any commitment that the [parties] made or to any injury they caused . . . ." *Eastern Enterprises*, 524 U.S. at 537.

III. CONCLUSION

A final word is in order about the controlling caselaw. We have applied principles espoused in a series of Supreme Court cases, each of which goes out of its way to emphasize the fact-specific nature of a Takings Clause decision. *See*, e.g., *Eastern Enterprises,* 524 U.S. at 523; *Connolly,* 475 U.S. at 224. While Eastern Enterprises seems factually closest to this case -- because of its long period of retroactivity, the imposition of unforeseen liability, and application to companies no longer in the market -- its takings clause rationale was accepted by only four justices, with Justice Kennedy concurring on a due process basis. *See Eastern Enterprises,* 524 U.S. at 539 (KENNEDY, J., concurring in the judgment and dissenting in part). Insofar as Justice Kennedy's specific dispute with the rest of the majority rested on the extent to which a regulatory taking must refer to an identifiable property interest or fund, we believe that dispute would be muted -- or mooted -- here. The assessments against these plaintiffs arise from the specific fund of benefits they pay to claimants in Louisiana each year. Further, the assessments are charged by the insurers against the fund of reserves set aside from the premiums collected under specific insurance policies. Otherwise, Justice Kennedy's due process analysis focuses on retroactivity and is essentially harmonious with the reasoning of the other four justices. *See id.* at 547-50 (KENNEDY, J., concurring in the judgment and dissenting in part).

The defendants rely on *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 106 S. Ct. 1018, 89 L. Ed. 2d 166 (1986), as the closest-fitting case to this one. In Connolly, however, the Court noted that employers were

continuously aware, during the entire period of retroactivity, not only that Congress was studying the funding mechanism for multiemployer pension plans but also that statutory withdrawal liability might be required. *See Connolly,* 475 U.S. at 226-27. In addition, the employers in Connolly were held responsible for pension plans for their employees or employees subject to multiemployer plans, *see id.* at 225. These plaintiffs, having previously been mere conduits for payments from and assessments to the SIF, are uniquely being forced to defray the cost of the SIF for other people's employees. Finally, there was rough proportionality in Connolly between an employer's assessment and its experience with the plan to which it had contributed, and provisions of the retroactive law moderated and mitigated its potential unfairness. *See id.* at 225-26. No such proportionality or mitigation exists in this case.

Act 188 as applied to plaintiffs' pre-enactment contracts retroactively imposes a heavy economic burden on those who could not reasonably anticipate the liability. The extent of the liability is disproportionate to the plaintiffs' experience with the SIF, and the legislation is unnecessary to substantially advance a legitimate state interest. *See Eastern Enterprises,* 524 U.S. at 528-29. To this extent, the statute effects an unconstitutional taking of plaintiffs' property without just compensation. The judgment of the district court is **REVERSED**, and the case is **REMANDED** for entry of appropriate injunctive relief.

REVERSED and **REMANDED**.

APPENDIX B

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF LOUISIANA

[Filed March 5, 1999]

CIVIL ACTION NO. 96-385-A

UNITED STATES FIDELITY AND GUARANTY COMPANY, ET AL	)
V.	)
W. FOX MCKEITHEN, ET AL	)

March 5, 1999, Decided

JUDGES:
Honorable John V. Parker, United States District Judge, Middle District of Louisiana.

OPINION

RULING ON MOTIONS FOR SUMMARY JUDGMENT

This matter is before the court on motions for summary judgment submitted by both the plaintiffs[1] and defendants[2] and a motion to dismiss by the defendants which

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[1] Plaintiffs in this case consist of the following private insurance companies: United States Fidelity and Guaranty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc. Argonaut Insurance Company, Argonaut Midwest Insurance Company, Argonaut Southwest Insurance Company, Commercial Union Insurance Company, American Central Insurance Company, American Employers' Insurance Company, Employers' Fire Insurance Company, Northern Assurance Company of America, United States Fire Insurance Company, North River Insurance Company, Insurance Company of North America, Banker's Standard Insurance Company, Century Indemnity Company, Cigna Fire Underwriters Insurance Company, Cigna Indemnity Insurance Company, Cigna Insurance Company, Cigna Property and Casualty Insurance Company, Cigna Specialty Insurance Company, Indemnity Insurance Company of North America, Pacific Employers Insurance Company, Hartford Accident and Indemnity Company, Hartford Casualty Insurance Company, Hartford Fire Insurance Company, Hartford Insurance Company of the Midwest, Hartford Insurance Company of the Southeast, Hartford Underwriters Insurance Company, Twin City Fire Insurance Company, Travelers Insurance Company, Aetna Casualty & Surety Company, Travelers Indemnity Company, Travelers Indemnity Company of America, Travelers Indemnity Company of Connecticut, Travelers Indemnity Company of Illinois, Charter Oak Fire Insurance Company, Phoenix Insurance Company, Liberty Mutual Insurance Company, Liberty Mutual Fire Insurance Company, and Liberty Insurance Corporation.

[2] Defendants, as set forth in the amended complaint dated August 27, 1996 are: the members of the Louisiana worker's

was converted into a motion for summary judgment by the court. There is no need for oral argument. Jurisdiction is based on federal question jurisdiction under 28 U.S.C. § 1331.

All motions were referred to Magistrate Judge Stephen C. Riedlinger for a report and recommendation under 28 U.S.C. § 636. The report and recommendation has been filed and both sides have filed objections thereto. Accordingly, the court reviews the entire matter *de nova*.

The facts are essentially undisputed and many of the "facts" are actually issues of law. The matter has been extensively briefed and the court has carefully reviewed all information submitted by all parties.

The court concludes that the magistrate judge's recommendation to grant defendants' motion for summary judgment on the Contract Clause claim and the Equal Protection claim is correct, and those conclusions of the magistrate judge's report are hereby adopted, although the court does not necessarily adopt all of his reasoning. The court also concludes, for reasons stated below, that the magistrate judge's recommendation to grant summary

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compensation board (which include the following: Louisiana Secretary of State W. Fox McKeithen, Louisiana State Treasurer Ken Duncan, Louisiana Director of Worker's Compensation Ron Menville, Louisiana Commissioner of Insurance James H. Brown, and Louisiana Secretary of Social Services Madlyn B. Bagneris), the Louisiana Secretary of Labor Robin M. Houston, and the Louisiana Commissioner of Insurance James H. Brown.

judgment in favor of plaintiffs on the Takings Clause claim is not correct and it is rejected.

BACKGROUND

All plaintiffs are insurance companies which now or formerly issued workers compensation policies of Louisiana employers. All have significantly reduced the number of policies sold in Louisiana in recent years and at least two of them have ceased issuing such policies at all.

In 1974 Louisiana, following the lead of many other states, established a second injury fund. According to L.R.S. 23:1371A, its purpose is:

> . . . To encourage the employment of physically handicapped employees who have a permanent, partial disability by protecting employers, group self-insurance funds, and properly and casualty insurers from excess liability for workers' compensation for disability when a subsequent injury to such an employee merges with his preexisting permanent physical disability to cause a greater disability than would have resulted from the subsequent injury alone.

The Fund is used to pay administrative expenses and to reimburse compensable second injury benefits paid by self-insured employers and insurers. Since no public monies were supplied, Louisiana requires that every insurer and self-insured employer pay annual assessments. LRS 23:1377B. The Fund has from its beginning operated on a year-to-year

basis; that is, all assessments collected in a calendar year are paid out in that year (at least in theory) and the Fund is replenished by the next year's assessments.

Initially, assessments upon insurers was calculated as a percentage of the gross premium volume for workers compensation policies sold in Louisiana the preceding year. Self-insured employers were assessed upon an estimate of the premium they would have paid had they been insured.

As the years passed and the numbers of workers compensation insurance policies issued in Louisiana decreased, so did premium volumes. The state increased the percentage of the assessment several times in order to obtain sufficient funds to pay claims.

In 1995, the Louisiana Legislature adopted Act 188 of 1995 which amended LRS 23:1377 B so as to require that annual assessments to the Fund be calculated as a percentage of the workers compensation benefits paid by insurers and self-insured employers. The Fund continues to reimburse insurers and employers in full for all compensable second injury benefit paid.

Under the old assessment procedure, plaintiff companies that had sharply reduced premium volumes also were paying sharply reduced assessments. Of course, in the case of companies that had stopped issuing new policies, there was no premium volume and hence no assessment. All plaintiff companies continued to pay claims on previously issued policies and all continued to claim and receive reimbursement from the Fund for all benefits paid each year.

Plaintiffs claim, and were able to convince the magistrate judge, that this change in the method of calculating annual assessments for the Fund constitutes a taking of their property without compensation in violation of the Fifth Amendment to the Constitution. They concede that a number of other states calculate such assessments upon benefits paid and that no constitutional or other challenge has been made in those states.

Plaintiffs have summarized their argument at pages 2 and 3 of their objection to the magistrate judge's report:

"In 1974, Louisiana established a Workers' Compensation Second Injury Fund to compensate previously-disabled workers for lost wages and medical care arising from a second occupationally-related injury. The Fund principally was financed by annual assessments on workers' compensation insurers, including plaintiffs, calculated as a percentage of the premiums collected under each insurer's contracts of insurance. However, . . . these assessments imposed no net cost on insurers because they were allowed to pass the assessments through to employers by means of increased rates. . . . The employers of the injured workers thus ultimately bore the cost of the system.

In the late 1980s and early 1990s, plaintiffs experienced severe losses in the Louisiana workers' compensation insurance market and either withdrew from the market or substantially reduced their underwriting in the state. . . . In response, Louisiana radically revised its assessment statute in an effort to shift the financial burden of the Second Injury Fund from employers to withdrawing insurers that no longer were collecting significant premiums in Louisiana. In

1995, the basis for assessments was changed from a percentage of premiums to a percentage of benefits paid out by the insurer to injured employees... By basing assessments on benefits rather than premiums, insurers could be assessed even though they no longer wrote a significant volume of business in Louisiana. Indeed, the 1995 change in the law expressly was made applicable to insurers that had ceased doing business in Louisiana . . . In substantial part, this change was retroactive because the assessments largely were based on benefits paid out under contracts entered into years and even decades before 1995.

The 1995 legislation fundamentally transformed the assessment system in two respects. First, a double assessment effectively was imposed on pre-1995 insurance contracts. Even though insurers previously had paid an assessment out of the premium dollars collected under the past contract, they were now compelled to pay a second assessment out of the same premium dollars needed to pay benefits to injured employees under that contract. Second, unlike the regime established under the 1974 statute, insurers no longer were allowed to recoup the second, retroactive assessment. This was because they no longer did business in Louisiana sufficient to permit them to recover the assessments by means of rate increases." (Citations omitted)

DISCUSSION

This court concludes that, contrary to the position advocated by plaintiffs, there is no taking here in the constitutional sense. Plaintiffs are simply seeking a "free ride" to reimbursement for second injury benefits paid by them under previously issued insurance policies (for each of which

the insured paid a premium) using money paid into the Fund by others. Plaintiffs are not "paying twice" and they are not being assessed "retroactively"; nor are they "deprived of the right" to recover assessments by passing that cost on to their insureds through increased insurance premiums because of Louisiana's change in assessment procedure.

In the context of a taking claim, regulatory taking occurs when the value or usefulness of private property is diminished by regulatory action that does not involve physical occupation of property.[3] The purpose of the Takings Clause is "'to bar government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole."[4] In order to establish a violation, "one must demonstrate both that 'property' was 'taken' and that no provision was made for awarding 'just compensation.'"[5]

If every statutory change were a taking, it would cripple the ability of federal and state legislatures to adjust the benefits and burdens of economic life. In the words of Professor Fuller, cited approvingly by the Supreme Court, 'If every time a man relied on existing law in arranging his

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[3] U.S.C.A. Const.Amend. 5.

[4] *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 227, 106 S. Ct. 1018, 1027, 89 L. Ed. 2d 166 (1986) (quoting *Armstrong v. United States*, 364 U.S. 40, 49, 80 S. Ct. 1563, 1569, 4 L. Ed. 2d 1554 (1960)).

[5] *Medical Malpractice Joint Underwriting Ass'n v. Paradis*, 756 F. Supp. 669, 675 (D.R.I.1991).

affairs, he were made secure against any change in legal rules, the whole body of our law would be ossified forever.' "[6]

The Supreme Court has regarded the Takings Clause as substantially similar to the doctrine of substantive due process and has given broad scope to legislative prerogatives to modify legal rules without having to compensate affected parties for the costs resulting from the changes. In cases analogous to this one, the Court has made that point explicitly, observing that it would be "surprising indeed to discover" that a statute that satisfied the Due Process Clause nonetheless violated the Takings Clause. *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 223, 106 S. Ct. 1018, 1025, 89 L. Ed. 2d 166 (1986); *Concrete Pipe & Prod. v. Const. Laborers Pen.*, 508 U.S. 602, 641, 113 S. Ct. 2264, 2289, 124 L. Ed. 2d 539 (1993)

In the *Connolly* and *Concrete Pipe*, cases, the Supreme Court upheld, against both Due Process and Takings Clause claims, statutory changes in pension law that resulted in the imposition of liability on companies that withdrew from multiemployer pension plans. The Court in Connolly began its takings analysis by noting that a statute establishing a new form of liability is a kind of regulatory statute that does not necessarily effect a taking:

'In the course of regulating commercial and other human affairs, Congress routinely creates burdens for some

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[6] Lon Fuller, The Morality of Law 60 (1964), quoted in *Landgraf v. USI Film Prods.*, 511 U.S. 244, n. 24, 114 S. Ct. 1483, 1499 n. 24, 128 L. Ed. 2d 229 (1994).

that directly benefit others. For example, Congress may set minimum wages, control prices, or create causes of action that did not previously exist. . . . Legislation readjusting rights and burdens is not unlawful solely because it upsets otherwise settled expectations.[7]

Although scholars expected that the Court's decision in *Eastern Enterprise v. Apfel,*[8] would provide insight to these relatively vague factors, it did not.[9] In that case, Eastern Enterprises ("Eastern"), a company which participated in coal mining from 1946 to 1965, was also involved in a series of labor negotiations over the provision of health and pension benefits with its employees. A nationwide strike and a 1946 Executive Order by President Truman to nationalize coal mining forced Coal Mining employers to sign the National Bituminous Coal Wage Agreement of 1947, an agreement providing health benefits to miners. In 1950 the agreement was modified to include lifetime guarantees for retirees, subject to possible alterations. The 1950 agreement remained the same until 1974, when a new collective bargaining agreement established mandatory lifetime benefits. After the 1974 agreement, years of financial crises ensued, prompting

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[7] 475 U.S. at 223, 106 S. Ct. at 1025 (quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16, 96 S. Ct. 2882, 2893, 49 L. Ed. 2d 752 (1976))."

[8] 524 U.S. 498, 118 S. Ct. 2131, 141 L. Ed. 2d 451 (1998), (1998).

[9] The Supreme Court 1997 Term, Leading Cases, I. Constitutional Law, E. Takings Clause, 112 Harv. L. Rev. 212 (1998).

the Congress to enact the Coal Industry Retiree Health Benefit Act of 1992, an effort to stabilize fund financing to safeguard retired miners' benefits. The Coal Act directed the Commissioner of Social Security to assign responsibility for each retiree to a mining company, based on the length of time the miner worked for each employer and each employer's prior participation. Eastern, however, had ceased its mining operations by the end of 1965, and its agreement with its employees prior to this time never contained lifetime benefit's provisions. Nevertheless, the Commissioner assigned it responsibility for more than 1,000 retirees at an annual cost of five million dollars. Eastern contested the assignment, claiming that it violated the Takings and Due Process Clauses.

In a plurality opinion by Justice O'Connor, the Court held that the Coal Act as applied to *Eastern* effected an unconstitutional taking. Recognizing that there is no "set formula" for identifying an unconstitutional taking forbidden by the Fifth Amendment, the court, relying on prior decisions, suggested "ad hoc, factual inquiries into the circumstances of each particular case." As in *Connolly*, the Court stated that there are three factors of "particular significance" to a regulatory taking's clause analysis: (1) the character of the government action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with reasonable investment-backed expectations.[10]

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[10] *Id. at 225, 106 S. Ct. at 1026; Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005, 104 S. Ct. 2862, 2874, 81 L. Ed. 2d 815 (1984).

While the factors used in *Eastern Enterprise* are proper in our Takings Clause analysis, the plaintiffs argue that our facts are also analogous. The court disagrees. The above factors as they applied to the plaintiff in *Eastern* represented a taking since it subjected it to an unexpected and actually retroactive liability for a problem which was not caused by any of the plaintiff's actions and which the plaintiff could not have predicted. As shown below, the plaintiffs in this case entered a highly regulated market, were subjected to an assessment which adjusted the benefits and burden of economic life upon them as a result of entering the market. The parties were aware that the law had no guarantee of remaining constant.

A. The Character of the Government Action

With regard to the first factor, Louisiana did not appropriate money for its own use. The assessment, whether premium-based or benefits-based, does not end up in the general coffers of the state. Quite the contrary, the purpose of the Second Injury Fund is to encourage employment of employees who have already sustained an injury. This is not a taking that deprives the plaintiffs of their property but rather is "a public program that adjusts the benefits and burdens of economic life to promote the common good."[11] The assessment in this case is a rational attempt by the state to impose the costs inherent in a certain type of business activity on "those who have profited from the fruits" of the

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[11] *Connolly v. Pension Benefit Guar. Corp* 475 U.S. at 225, 106 S. Ct. at 1026.

business in question.[12] The need for such a fund and the subsequent change in the assessment procedure is not one which the entire state should bear. Rather, its need is directly related to the employers' refusal to hire already injured and partially disabled workers because of the fear that a second injury would increase workers compensation costs, whether by insurance premiums or payment of benefits.

A violation of the Takings Clause requires more than the government's use of a person's property. To succeed, a party must also show that the taking was without just compensation.[13] The adoption of Act 188 of 1995 has not changed the character of Louisiana's action. The only change is the procedure for assessment. The purpose of imposing the new basis for assessment was to enable the Second Injury Fund to remain adequately funded. Insurers are still allowed to recover the cost of the assessment through the rate-making process just as they were prior to the 1995 Act. The fact that some companies have withdrawn or significantly reduced their business in Louisiana does not alter the fact that "a reasonable, certain and adequate provision for obtaining compensation" was provided at the time of the alleged taking.[14]

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[12] *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 18, 96 S. Ct. 2882, 2893, 49 L. Ed. 2d 752 (1976).

[13] U.S.C.A. Const.Amend. 5.

[14] *Liberty Mutual Insurance Co. v. Whitehouse*, 868 F. Supp. 425 (D.R.I. 1994), citing, *Metropolitan Transp. Auth. v. ICC*, 792 F.2d 287, 296-97 (2d Cir.), cert. denied, 479 U.S. 1017, 107 S. Ct. 669, 93 L. Ed. 2d 721 (1986).

B. The Economic Impact of the Regulation on the Claimant

No doubt the impact of Act 188 of 1995 on the plaintiff companies could be heavy. However, the assessment in this case is proportionate with defendant's experience with the Fund. The insurers who have left or who have substantially reduced their underwriting in Louisiana are not required to pay more than their experience with the Second Injury Fund justifies. The plaintiffs do not make any claim that they will pay a greater amount or an amount that is not proportionate to what others will pay with regard to the Second Injury Fund. There clearly was no contractual obligation between the state and the plaintiffs which required the assessment to remain premium based. Furthermore, workers compensation insurance in Louisiana is a heavily regulated field, and the assessment, both before and after the 1995 amendment, is "a necessary consequence of the [state's] regulatory scheme."[15] Changes in the way government chooses to operate in this field or more specifically, changes in the way government assesses companies that wish to participate in the workers compensation industry were never guaranteed by the state, although this may have been the hope of the plaintiff companies.

C. Investment Backed-Expectation

In *Eastern*, the plurality found that the Coal Act "substantially" interfered with the investment-backed expectations of the plaintiff. The plurality supported this claim

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[15] 475 U.S. at 226, 106 S. Ct. at 1027.

by recounting the law's centuries-old disdain for retroactivity and noting that the Coal Act attached liability to conduct in which Eastern had engaged thirty to fifty years ago, at which time there was no understanding that miners would receive lifetime benefits. In *Eastern*, the plurality was concerned that the problem for which a party is held liable must be one at least partly of its own creation.

Act 188, however, is not retroactive. Prior to the enactment of the 1995 amendment, the law required workers compensation insurers and self-insured employers to pay assessments on a premium-volume basis. The assessment was based on the premiums collected in the previous year. The Fund then reimbursed companies and employers who paid benefits to persons with second injuries. At the end of the year, the Fund should in essence be depleted, and then replenished by a new assessment. Plaintiffs, like all others who chose to participate in the worker's compensation industry, paid yearly.

Act 188 changed the assessment procedure only, it did not change the character or the purpose of the Fund. It did not reach back, as in *Eastern*, and single out a particular class of persons to bear substantial costs, based on past conduct not related to those costs. The problem created in this case is one that is a result of the plaintiffs' own creation. Because the plaintiffs substantially reduced or are no longer underwriting and collecting premiums, the fund was no longer being adequately funded. Nevertheless, plaintiffs continued to reap the benefits of the Fund by collecting reimbursements for benefits paid under insurance contracts that they had written in the past. Thus, Act 188 does not seek to hold the plaintiffs liable for their past actions, rather it seeks to hold them

responsible for their present actions by making everyone that is now paying benefits also pay an assessment. The assessment is directly related to the reimbursement benefits they presently receive, and not related to past acts.

Furthermore, the time for considering investment backed expectations is the time the property is acquired, not the time the challenged regulation is enacted.[16] A regulatory taking occurs when a change in the law results in the immediate impairment of property rights, leaving the property owner no other options to avoid the loss.[17] Plaintiffs claim that this act violated their investment backed expectations because they no longer have any way of recouping or passing on the costs imposed since they have reduced or ceased underwriting in Louisiana. This argument is unpersuasive.

CONCLUSION

It bears repeating that the Second Injury Fund is not insurance; it was never underwritten as such and assessments paid by plaintiffs were never intended to be considered in any sense a "premium" payment for insurance. The Fund was and is a new fund each year; that is, the total amount of benefits to be paid for the next year is estimated and the assessment necessary to pay those benefits in that year is made. Thus, each fund year stands on its own bottom.

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[16] *Yancey v. United States*, 915 F.2d 1534, 1540 (Fed. Cir. 1990).

[17] *See Lucas v. South Carolina Coastal Council*, 505 U.S. 1003, 112 S. Ct. 2886, 120 L. Ed. 2d 798 (1992).; and *Connolly*.

The State of Louisiana has little or no interest in how the assessed insurance companies acquire the means with which to pay the assessment; the state's interest is in having a second injury fund in an amount sufficient to pay benefits for each individual year. Assessments predicated upon premiums earned in Louisiana was an easy and convenient basis for making assessments when the fund was established in 1974. The state has set out a number of reasons why other bases were not used at that time and this court can not say that those suggestions were unreasonable or inappropriate or irrational. Obviously, funding must come from somewhere if there is to be a fund at all.

As this court understands their argument, plaintiffs want this court to declare that they are entitled to seek reimbursement from the fund for each year that they pay benefits in Louisiana but without the necessity of making any contribution to the Fund. If assessments were continued on the basis of premium volume, plaintiffs would effectively pay benefits under previously underwritten policies using other people's money; they would be reimbursed for all benefits paid but make no or very little contribution to the Fund.

In this court's view, the State of Louisiana has found a rational method of requiring those companies who benefit from the Second Injury Fund to also contribute to it. Under these circumstances, there is no taking of property from these plaintiffs by Louisiana in violation of the Constitution.

If the plaintiff companies were required to make contributions to the Fund from which they could not seek reimbursement, then their argument of an unconstitutional appropriation of their property would have more validity.

For the foregoing reasons, the motion for summary judgment filed on behalf of plaintiffs (doc. 33-1) is hereby DENIED; the motion for summary judgment filed on behalf of defendants (doc. 44-1) is hereby GRANTED and this action shall be dismissed.

Baton Rouge, Louisiana, March 5, 1999.
JOHN V. PARKER,
UNITED STATES DISTRICT JUDGE
MIDDLE DISTRICT OF LOUISIANA

APPENDIX C

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

[Filed October 4, 1998]

Civil Action No. 96-385-B-MI

UNITED STATES FIDELITY AND GUARANTY COMPANY, ET AL	)
V.	)
W. FOX MCKEITHEN, ET AL.	)

DISPUTED ISSUES OF MATERIAL FACT

1. Defendants dispute plaintiffs' proposed fact number 1 in that reimbursement was only permitted in accordance with the applicable law.

2. Defendants dispute plaintiffs' proposed fact number 3 in that they have no way of knowing whether every contract issued by every plaintiff had the referenced language in it prior to the effective date of Act 188.

3. Defendants dispute plaintiffs' proposed fact number 4, in that the Second Injury Fund had a net cost impact on insurers in some years.

4. Defendants dispute plaintiffs' proposed fact number 5, in that the insurance industry is regulated by the state, can be subject to changes in the law and in that the insurance industry was aware of proposed changes at issue well prior to the effective date of Act 188.

5. Defendants dispute plaintiffs' proposed fact number 6 for the same reasons stated concerning their proposed fact number 5.

6. Defendants dispute plaintiffs' proposed fact number 8 for reasons stated in its opposition memorandum.

7. Defendants dispute plaintiffs' proposed fact number 9 for reasons stated in its opposition memorandum.

8. Defendants dispute plaintiffs' proposed fact number 10 for reasons stated in its opposition memorandum.

9. Defendants dispute plaintiffs' proposed fact number 11 for reasons stated in its opposition memorandum, and also in that the insurance industry was aware of proposed changes at issue well prior to the effective date of Act 188.

10. Defendants dispute plaintiffs' proposed fact number 12 for reasons stated in its opposition memorandum.

11. Defendants dispute plaintiffs' proposed fact number 14 for reasons stated in its opposition memorandum.

12. Defendants dispute plaintiffs' proposed fact number 16 for reasons stated in its opposition memorandum.

13. Defendants dispute plaintiffs' proposed fact number 17 for reasons stated in its opposition memorandum.

14. Defendants dispute plaintiffs' proposed fact number 18 for reasons stated in its opposition memorandum.

15. Defendants dispute plaintiffs' proposed fact number 19 for reasons stated in its opposition memorandum.

16. Defendants dispute plaintiffs' proposed fact number 20 for reasons stated in its opposition memorandum.

17. Defendants dispute plaintiffs' proposed fact number 21 for reasons stated in its opposition memorandum.

18. Defendants dispute plaintiffs' proposed fact number 22 for reasons stated in its opposition memorandum.

19. Defendants dispute plaintiffs' proposed fact number 23 for reasons stated in its opposition memorandum.

20. Defendants dispute plaintiffs' proposed fact number 24 for reasons stated in its opposition memorandum.

21. Defendants dispute plaintiffs' proposed fact number 25 for reasons stated in its opposition memorandum, and also on the grounds that this is not material to this case.

22. Defendants dispute plaintiffs' proposed fact number 26 in that total assessments are anticipated to slightly increase.

Respectfully Submitted:

RICHARD P. IEYOUB
ATTORNEY GENERAL

BY: /s/_____
JAMES C. HRDLICKA
Assistant Attorney General
LSBA#7037

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APPENDIX D

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[Filed October 25, 2000]

No. 99-30475

UNITED STATES FIDELITY AND GUARANTY CO; ET AL.
Plaintiffs,

UNITED STATES FIDELITY AND GUARANTY CO; FIDELITY & GUARANTY INSURANCE CO; FIDELITY & GUARANTY INSURANCE UNDERWRITERS, INC; ARGONAUT INSURANCE COMPANY; ARGONAUT MIDWEST INSURANCE COMPANY; ARGONAUT SOUTHWEST INSURANCE COMPANY; COMMERCIAL UNION INSURANCE COMPANY; AMERICAN CENTRAL INSURANCE; AMERICAN EMPLOYERS' INSURANCE COMPANY; EMPLOYERS FIRE INSURANCE COMPANY; THE NORTHERN ASSURANCE COMPANY OF AMERICA; UNITED STATES FIRE INSURANCE COMPANY; NORTH RIVER INSURANCE COMPANY; INSURANCE COMPANY OF NORTH AMERICA; BANKER'S STANDARD INSURANCE COMPANY; CENTURY INDEMNITY CO; CIGNA FIRE UNDERWRITERS INSURANCE COMPANY; CIGNA INSURANCE CO;

CIGNA PROPERTY & CASUALTY INSURANCE)
COMPANY; CIGNA SPECIALITY INSURANCE)
COMPANY; INDEMNITY INSURANCE COMPANY)
OF NORTH AMERICA; PACIFIC EMPLOYERS)
INSURANCE COMPANY; HARTFORD ACCIDENT)
AND CASUALTY COMPANY; HARTFORD)
CASUALTY INSURANCE COMPANY; HARTFORD)
FIRE INSURANCE COMPANY; HARTFORD)
INSURANCE COMPANY OF THE MIDWEST;)
HARTFORD INSURANCE COMPANY OF THE)
SOUTHEAST; HARTFORD UNDERWRITERS)
INSURANCE COMPANY; TWIN CITY FIRE)
INSURANCE COMPANY; TRAVELERS INSURANCE)
COMPANY; TRAVELERS INDEMNITY COMPANY)
OF AMERICA; THE TRAVELERS INDEMNITY)
COMPANY; THE TRAVELERS INDEMNITY)
COMPANY OF CONNECTICUT; THE TRAVELERS)
INDEMNITY COMPANY OF ILLINOIS; CHARTER)
OAK FIRE INSURANCE COMPANY; PHOENIX)
INSURANCE COMPANY; AETNA CASUALTY &)
SURETY COMPANY; CIGNA INDEMNITY)
INSURANCE COMPANY; LIBERTY MUTUAL)
INSURANCE COMPANY; LIBERTY MUTUAL FIRE)
INSURANCE COMPANY; LIBERTY INSURANCE)
CORPORATION)
Plaintiffs - Appellants,)
)
v.)
)
W FOX MCKEITHEN, Etc; ET AL)
Defendants,)
)
W FOX MCKEITHEN, Louisiana Secretary of State;)

KEN DUNCAN, Louisiana State Treasurer; GLYNN VOISIN, Judge, Director of Workers' Compensation of Louisiana; JAMES H BROWN, Louisiana Commissioner of Insurance; MADLYN B BAGNERIS, Secretary of Social Services of Louisiana, in their official capacities as members of the Louisiana Workers' Compensation Second Injury Board; CHRIS WEAVER, Acting Secretary, Louisiana Department of Labor

Defendants - Appellees.

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge

ON PETITION FOR REHEARING EN BANC

(Opinion 09/15/00, 5 Cir., _____ , _____ F.3d _____)

Before JONES, DUHE, and WIENER, Circuit Judges.

PER CURIAM:

(X) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. APP. P. and 5TH CIR.R. 35), the Petition for Rehearing En Banc is DENIED.

( ) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. The court having been polled at the request of one of the members of the court and a majority of the judges who

are in regular active service not having voted in favor (FED. R. APP. P. and 5TH. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/s/ _____
United States Circuit Judge

REHG-6a

CLERK'S NOTE:

SEE FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF LOUISIANA

Civil Action No. 96-385-B-MI

UNITED STATES FIDELITY AND GUARANTY COMPANY, et al., *Plaintiffs*,	)
v.	)
W. Fox McKeithen, et al., *Defendants.*	)

AFFIDAVIT OF JAMES E. CAMPBELL

East Baton Rouge Parish)
State of Louisiana)

I, James E. Campbell, being duly sworn, state as follows:

1. I am presently the second Injury Board Director. I was hired in 1974, at the inception of the Second Injury Board, as "Executive Director," and years later, my title was changed to Second Injury Board Director.

2. My duties consist of advising the Board and recommending policies, legislation and other operations of the Louisiana Second Injury Board. I am responsible for overseeing the operations of the Board, including the processing of claims, annual assessments, Rules and Regulations and day-to-day operations of the Board.

3. I am very familiar with the Workers' Compensation Laws of Louisiana and the Louisiana second Injury Fund. Over the years, I have studied the operations of, and visited, other state Second Injury Funds.

4. I am basically familiar with the operations of insurance companies and self-insured employers, as to their processing claims, establishing reserves and the premiums for insurance policies.

5. Prior to employment with the Second Injury Board, I spent about seven years in the claims business, handling a lot of workers' compensation claims, setting reserves on claims, etc. Two of those years were with an insurance company.

6. I was instrumental in drafting Act 188, and recommending it to the Board for passage in the Legislature.

7. The Louisiana Workers' Compensation Board (Board) and the Louisiana Workers' Compensation Second Injury Fund (Fund) were created in 1974. (LA B.S. 23:2371 et seq.)

8. The purpose of the Fund was to encourage the employment of handicapped employees who have a permanent

partial disability, by protecting employers from excess liability for workers' compensation, in certain cases.

9. The Second Injury Fund is designed to encourage employers to hire and retain the handicapped by reimbursing the employer if self-insured or, if insured, the insurer for part of the workers' compensation cost.

10. In order to fund this program, an annual assessment is made upon insurance companies, self-insured employers and group self-insured funds.

11. Upon the inception of the Fund in 1974, the assessment was as follows:

> Every insurer shall make an annual payment into the Workmen's Compensation Second Injury Fund of an amount equal to one percent of the gross premium received by the insurer for workmen's compensation insurance the preceding calendar year, but not less than ten dollars. Every self insurer shall make an annual payment into the fund of an amount equal to one percent of the workmen's compensation insurance premium that would have been paid had the self insurer been insured, but not less than ten dollars, such payment shall be computed by applying the approved manual rate, applicable to the self insurer's operations, in effect January 1 of the year the payment is due, to the payroll of the self insurer for the preceding calendar year, subject to the same payroll limitation rules

applicable in computing the premium for an insured employer.

R.S. 23:1377 (B)

a. The Model Act and the National Commission's report had recommended that Second Injury Funds be funded by an assessment on benefits paid.

b. Louisiana elected to use an assessment on premiums, as do many other states. Approximately 13 states use the premium assessment rather than benefits paid.

c. In 1974, Louisiana was unique in its Workers' Compensation Laws due to the fact that there was no Workers' Compensation Commission or Agency as in most other states.

d. As a result, there was no licensing for self-insured employers, and there was no known list of self-insured employers. Also, not all employment was covered by workers' compensation. R.S. 23:1035 specified that hazardous employment was covered by listing a large number of specific occupations.

e. Non-hazardous occupations were not necessarily covered by workers' compensation, but the employer and employee could agree to come under the Act.

f. Most states, except Louisiana, had some sort of Workers' Compensation Commission or Agency, that either licensed or had a list of the self-insurers and insurance companies, etc.

g. In 1974, Louisiana only had the Insurance Commission, and the insurance carriers had to report annually, as they still do, as to the total premiums written in a calendar year. There was no state agency that compiled records on "benefits paid."

h. Also in 1974, most of the employers were insured by an insurance company. Self-insurance has grown tremendously over the past years. In 1995, self-insurance was about fifty percent of the entire Workers' Compensation in Louisiana.

i. Louisiana did not create a Workers' Compensation Agency until 1983, and it is now called the Office of Workers' Compensation (OWC). The OWC funds its office by an assessment on benefits paid. They license self-insurers and compile annual reports on benefits paid by insurance carriers and self-insurers.

j. In 1974, Louisiana was unique in creating a Second Injury Fund, yet there was no Workers' Compensation Commission. Louisiana could easily bill and verify the premium assessments. A benefits paid assessment was not practicable because Louisiana did not have records on benefits paid by insurance companies and self-insurers.

12. R.S. 23:1377 was amended several times raising the percentage of the assessments.

13. REASONS FOR CHANGE:

a. The prior assessment on premiums was flawed. The assessment was based on premiums earned by insurance

companies which was fairly easy to ascertain, as the insurance companies submitted an annual report to the Commissioner of Insurance, giving the amount of premiums earned. Self-Insurers were being assessed on the manual rates, "for Assigned Risk Policies" effective January 1, 1990. The reason self-insurers, were assessed in this manner is that in 1988, regular manual rates were no longer promulgated, but only rates for the "Assigned Risk Pool." The assigned risk pool was composed of employers that could not obtain insurance coverage from insurance companies. The insurance companies declined to provide the coverage for a variety, of reasons, among them being reluctance to cover small employers. The insurance companies have always been reluctant to write coverage on a small employer because premiums generated would generally be sufficient to cover only minimal claims. The insurance companies had to write a percentage of the employers in the assigned risk pool, at extremely high rates called "Assigned Risk Manual Rates."

b. In 1992, the Assigned Risk Pool was abolished and replaced by the Louisiana Workers' Compensation Corporation; therefore, no manual rates, not even "Assigned Risk Rates," were promulgated.

c. The Second Injury Board was in a dilemma, since they were assessing self-insurers on 1990 assigned risk rates and insurance carriers on earned premiums. Obviously, the assessment was not on an equal basis between self-insurers and insurance carriers. In 1994, the total Second Injury Fund Assessment was about 50% from the self-insureds and 50% from employers covered by insurance policies. It was determined that the Second Injury Fund needed, and was

forced, to make changes to the Second Injury Fund Assessment.

d. The Second Injury Fund chose an assessment on benefits paid, as it was almost impossible to use premiums as the self-insurers could not compute premiums, or would have a most difficult time as there was no certain standard.

e. In order to fund the Office of Workers' Compensation, it assesses insurance companies and self-insurers on a percentage of benefits paid out. The insurance companies and self-insurers report annually to the Office of Workers' Compensation the total benefits paid out in a calendar year, in accordance with R.S. 23:1291.

f. Every insurance company writing workers' compensation in Louisiana and every self-insured employer is required to report, annually, the total compensation benefits paid, and open reserves, in a calendar year to the Office of Workers' Compensation on form LDOL-WC-1000. The LDOL-WC-1000 is then used by the Office of Workers' Compensation to bill the insurance companies and self-insurers a percentage of the benefits paid in order to fund the operations of the Office of Workers' Compensation. (See Exhibit 1)

g. Based on the 1995 figures reported to the Office of Workers' Compensation, the complaining insurance companies were assessed a combined total of $5,963,489.00 by the Second Injury Fund. The Second Injury Fund reimbursed the plaintiffs a combined total of $6,995,422.00. This is a reimbursement benefit of $1,031,933.00 to the insurance companies. (Exhibit 2)

h. The Second Injury Fund decided to use the same assessment method as the Office of Workers' Compensation, except that the percentage assessed against total benefits paid would be different. The Office of Workers' Compensation has been funded by this method since 1983, with no known objection from the insurance industry, and this is basically what the Model Act for Second Injury Funds had recommended for over 20 years.

i. The Second Injury Fund could simply use the annual reports (form LDOL-WC-1000) on benefits paid compiled by the Office of Workers' Compensation. This made the assessment simple, as we did not have to compile such records, but simply use those supplied to the Office of Workers' Compensation.

j. The old method of computing assessments for self-insured employers was extremely complicated, as we had to use the rules of the NCCI, etc., and it was also burdensome on the employers. The assessment on benefits saved time and money for the Second Injury Fund and self-insured employers. Many of the self-insured employers had to have outside CPA's and accounting firms to prepare their assessments; therefore, the Second Injury Fund simply followed almost exactly the procedure used by the Office of Workers' Compensation.

k. An assessment on premiums also has some inequities, as employers who buy a workers' compensation policy (insureds) and employers who are self-insured may not be comparable.

l. An insurance premium is designed collect sufficient funds from employers to cover all the costs and expenses of the insurance company in a profitable manner. Probably sixty percent of the premium charge is traditionally allocated to the payment of claims. The other forty percent covers administrative costs, principally underwriting, claims handling defense, and overhead. It also includes agents' or brokers' commissions of five to ten percent of the total premium, and five to ten percent of the total premium is allocated for profit.

m. All of the above costs and charges are translated by the insurance industry into a "manual rate" for each of several hundred job classifications. This "manual rate" is expressed for each job classification as "X" dollars per $100.00 of payroll. There is a different "manual rate" for the listed jobs, from clerks to carpenters to window washers to structural iron workers.

n. These "manual rates" are compiled and published for all insurance companies writing workers' compensation by the National Council on Compensation Insurance, a wholly owned agent of the workers' compensation insurance companies. This National Council purports to maintain a "data bank" embodying all the experience of all insurance companies in respect to the claims and costs involved for each of these job classifications.

o. Self-insurers, usually the larger companies in a state, suffer a distinct prejudice when forced to pay assessments on the basis of the high manual rate computations. The computation forces a higher artificial premium, and assessment base, on self-insurers than the

insurance industry imposes in its own operations on insured employers, where manual premiums are seldom the basis for actual premiums.

p. In recent years, many insurance companies offer "high deductible policies" to large employers. Under these policies, the insured employer retains and pays a substantial portion (called his "retention") of his workers' compensation costs. The insurance company insures only the excess over this "retention," producing a premium which does not reflect the full workers' compensation costs of that insured employer. This smaller premium conceals a much higher cost workers' compensation problem, and is an unfair basis for the required assessment for common funds, unfair among insured employers, and even more unfair to self-insured employers.

q. Aside from the inequities listed above, an insurance premium includes the estimates of the insurance company of the future costs of claims already incurred. These are called the insurance "reserves." They are merely estimates.

r. Self-insurers have no agents' commissions to pay, and are obviously not engaged in workers' compensation for profit. Consequently, the various costs and charges included in insurance premiums are simply inapplicable to self-insurers.

s. "Benefits paid" is an objective figure, easily verifiable in an audit of any employer.

t. "Benefits paid" is an actual figure, containing no estimates, and no influence by subjective or tangential factors.

u. "Benefits paid" fairly reflects the use of the state's workers' compensation program by each employer. Those with higher claims activity pay more than those with lower activity.

v. Prior to 1995, the Second Injury Fund did not have the staff to audit the assessments. The Office of Workers' Compensation internal audit, and legislative auditors wanted the Second Injury Fund to audit the insurance companies and self-insured employers, as to the accuracy of the payments to the Second Injury Fund.

w. In order to audit the payments, it would have been very expensive to the Second Injury Fund, as auditors would have to be hired and travel all over the state and outside state. The Second Injury Fund would have to hire more than several auditors, pay the expense of constant travel, etc.

x. The Office of Workers' Compensation already had auditors that were auditing the assessments. By adopting the assessment of the Office of Workers' Compensation, the Second Injury Fund got the benefit of those audits, at no cost, thus realizing a huge administrative savings.

14. Prior to Act 188, an insurance company could stop writing workers' compensation in Louisiana, or a self-insured could cease to be self-insured, and have over a hundred claims filed with the Second Injury Fund. The

Second Injury Fund has to reimburse the insurance company or self-insured for the life of the claim. Some of the claims may be reimbursed for ten or twenty years. Since the insurance company is no longer writing premiums, they would owe no assessment prior to Act 188.

15. The same problem exists with self-insured employers and self-insured group funds if they cease to be self-insured.

16. The plaintiffs in this case maintain that the reimbursements from the Second Injury Fund, on the runoff of claims, is not a windfall. The plaintiffs maintain that they gave the employers a reduction in premiums. There is no evidence that the employers of Louisiana received such a reduction in premiums.

17. The Louisiana Second Injury Fund can make only one assessment per year, and the monies collected each year are sufficient to only pay benefits that become payable that year.

18. The prior assessments on premiums were really assessments on the employers of Louisiana, who bought a workers' compensation policy. The insurance companies simply raised their rates on workers' compensation policies to cover the Second Injury Fund Assessment; therefore, there was no net cost to the insurance companies. The employers of Louisiana actually paid the assessment.

19. When an insurance company writes a workers' compensation policy, the premiums collected for that policy are intended to pay for all claims arising during the policy

period, no matter how far into the future they may have to pay for the claim. Some of the claims may be for the life of the employee and may be paid for ten or twenty years.

20. Under Act 188, the assessment is on a percent of benefits paid, but each annual assessment is to pay claims for one year.

21. Act 188 was, in no way, an attempt to punish insurance companies for ceasing to write workers' compensation in Louisiana, or to punish self-insured employers for ceasing to be self-insured. Act 188 applies, equally to insurance companies and self-insured employers.

22. Mr. Peter S. Bart's affidavit states that I testified before the House Committee on Labor and Industrial Relations on April 5, 1995 concerning Act 188.

23. I have reviewed the minutes and the tape concerning the testimony on Act 188. The tape clearly shows that I did not testify on H.B. 2204, Act 188.

24. The minutes clearly show that the Law applied equally to self-insured employers and insurance carriers.

25. The insurance companies were aware of this legislation, prior to its passage, through their lobbyist, and they did not object, nor did they testify at the Legislative Committee Meetings in opposition to Act 188. In fact, Act 188 passed without any opposition. The insurance companies had every opportunity to submit objections to the Second Injury Board prior to the passage of Act 188, but did not do

so. In fact, the lobbyist for the insurance companies had no objection.

26. Act 188 was simply an attempt to create a fair assessment for the employers of Louisiana.

27. The assessment should be equal for all employers, self-insurers and the employers who buy workers' compensation policies. The assessment should be against a figure that can be verified, not on figures that rely on estimates and are not verifiable.

28. Act 188 bases the assessment on "benefits paid," which is easily audited and verifiable. "Benefits paid" is a fairer assessment to all the employers of Louisiana, as those employers with higher claims activity pay more than employers with lower claims activity.

29. Act 188 appears to be the best policy for the employers of Louisiana.

/s/_____
James E. Campbell

Subscribed and sworn to before me, a Notary Public in the State of Louisiana on this 3 day of October, 1996.

/s/ _____
Notary Public

APPENDIX F

OFFICE OF WORKERS' COMPENSATION ADMINISTRATION

ANNUAL REPORT OF WORKERS' COMPENSATION COSTS

[Fold-Out]

State of Louisiana
Department of Labor
OFFICE OF WORKERS' COMPENSATION ADMINISTRATION
P.O. Box 94040
Baton Rouge, Louisiana 70804-9040

ANNUAL REPORT OF WORKERS' COMPENSATION COSTS

For Calendar Year _____

1. EMPLOYER INFORMATION	2. INSURANCE COMPANY INFORMATION
Fed. EIN: / Phone Number: ( )	

3. Coverage provided by: ☐ Self-Insured / Excess Insurance ☐ Conventional Worker's Compensation Policy ☐ Combination of Insurance Policies [R.S. 23:1168(A)(2)]
(See Instructions)

4. COSTS INCURRED DURING THE CALENDAR YEAR (See Instructions)

	Paid by Employer	Paid by Insurance
A. Indemnity Benefits:		
1. Temporary Total		
2. Permanent Total		
3. Permanent Partial		
4. Supplemental Earnings		
5. Death Benefits		
6. Compromise/Lump Sum Settlements		
7. Penalties & Interest		
TOTAL INDEMNITY BENEFITS		
B. Medical Benefits:		
1. Hospital Costs		
2. Physician Costs		
3. Prescription Drugs		
4. Independent Medical Exam		
5. Medical Rehabilitation		
6. Transportation		
TOTAL MEDICAL COSTS		

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	Paid by Employer	Paid by Insurance
C. Rehabilitation Benefits:		
1. Vocational Rehabilitation		
2. Labor Market Surveys		
3. Evaluations Ordered by Director		
4. Evaluations Ordered by the Court		
TOTAL REHABILITATION COSTS		
D. Legal Costs:		
1. Attorney fees		
2. Court Costs		
3. Deposition Costs		
4. Administrative Costs		
TOTAL LEGAL COSTS		
E. COST SUMMARY:		
1. Total Indemnity Benefits (A)		
2. Total Medical Benefits (B)		
3. Total Rehabilitation Costs (C)		
4. TOTAL ASSESSABLE COSTS (1+2+3)		
5. Total Legal Costs (D)		
6. TOTAL WORKERS' COMPENSATION COST (4+5)		
F. NUMBER OF CLAIMS SUMMARY		
1. Carried over from prior year		
2. Opened during current year		
3. Closed during current year		
4. Open at year end (1-2-3)		
5. Total Medical only claims		
G. OPEN RESERVE CLAIMS Number		
(at year end) Amount		

NOTE: The amount of compensation benefits paid will be used by the Director to make assessments for the administration of the Workers' Compensation Office under the provisions of Act 29, 1983, R.S. 23 §1291.1. All other information submitted will be used for statistical records only with the names of employers and carriers being confidential and privileged. (LA R.S. 23:1293)

FOR OFFICIAL USE ONLY	I certify that the information contained herein is true and correct to the best of my knowledge and belief.
	Signature _____ Date _____

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1995 SECOND INJURY FUND

ASSESSMENT AND BENEFITS PAID

The following chart is designed to show what the plaintiffs paid into the Second Injury Fund in 1995 and the benefits received rom the Second Injury Fund in Calendar Year 1995.

The 1995 Assessment was due by December 29, 1995, and it was based upon the benefits paid out by the insurance company for Calendar Year 1995. This is the first assessment under Act 188.

COMPANY GROUP	1995 ASSESSMENT	SECOND INJURY FUND 1995 REIMBURSEMENTS
U. S. F. & G.	$ 592,028.00	$ 336,254.00
Argonaut	$ 23,487.00	0
Cigna	$1,341,434.00	$ 898,510.00
Crum & Forster	$ 385,816.00	$ 335,580.00
Commercial Union	$ 350,179.00	$ 702,533.00
ITT Hartford	$ 386,506.00	$ 510,995.00
Liberty Mutual	$ 939,757.00	$1,384,598.00
Travelers	$1,197,500.00	$1,648,531.00
Aetna	$ 746,782.00	$1,178,421.00
TOTAL	$5,963,489.00	$6,995,422.00

The above chart clearly shows that five of the companies received more from the Second Injury Fund than they paid in 1995. Collectively, they received $1,031,933.00 more than they paid in.

Collectively, the insurance companies above wrote approximately $34,296,400.00 in workers' compensation premiums in Calendar Year 1994. We assume that they charged an extra 2.75%, which was the old assessment, and this amounts to $943,151.00, which is pure profit since they did not have to remit this to the Second Injury Fund. This brings the collective total to $1,975,084.00, more than they paid in the 1995 Assessment.

Without Act 188, most of the companies would have paid very little assessment or none at all.